INTERVIEW QUESTION

Name:_____

Date:_____

When can you start?_____

_____

What shifts can you work?_____

_____

Have you done this type of work?_____

_____

Do you have reliable transportation?_____

_____

Where are you located?_____

_____

Is traveling an issue?_____

_____

PRINT_____

SIGN_____ DATE ___/___/_____

BETTER IS BETTER
EMPLOYMENT APPLICATION

APPLICANT INFORMATION

LAST NAME:	FIRST NAME:	M.I	TODAY DATE:
STREET ADDRESS:		APARTMENT/UNIT#:	
CITY:	STATE:	ZIP CODE:	
PHONE:	EMAIL:	SOCIAL SECURITY #	
START DATE:	POSITION APPLIED FOR:		
ARE YOU LEGALLY ELIGIBLE TO WORK IN THE U.S.? YES ☐ NO ☐			
HAVE YOU EVER WORKED FOR THIS COMPANY? YES ☐ NO ☐ IF YES, WHEN:			
HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES ☐ NO ☐ IF YES, EXPLAIN:			

EDUCATION

HIGH SCHOOL:		ADDRESS:	
FROM:	TO:	DID YOU GRADUATE? YES ☐ NO ☐	DEGREE:
COLLEGE		ADDRESS:	
FROM:	TO:	DID YOU GRADUATE? YES ☐ NO ☐	DEGREE:
OTHER:		ADDRESS:	
FROM:	TO:	DID YOU GRADUATE? YES ☐ NO ☐	DEGREE:

EMPLOYMENT HISTORY

COMPANY:	FROM:	TO:
ADDRESS:	PHONE:	
SUPERVISOR:	RESPONSIBILITIES:	
COMPANY:	FROM:	TO:
ADDRESS:	PHONE:	
SUPERVISOR:	RESPONSIBILITIES:	
COMPANY:	FROM:	TO:
ADDRESS:	PHONE:	
SUPERVISOR	RESPONSIBILITIES:	

Employees References

NO FAMILY OR FRIENDS
NAME:
PHONE:
ASSOCIATION:
NAME:
PHONE:
ASSOCIATION:
NAME:
PHONE:
ASSOCIATION:

For Employer Only

RATE EMPLOYEE 1-5. 1 BEING LOW SATISFACTORY AND 5 BEING HIGH SATISFACTORY

REFERENCE	ONE
HOW WOULD YOU RATE HIS/HER WORK ETHICS?	1 2 3 4 5
HOW WOULD YOU RATE HIS/HER RELIABILITY?	1 2 3 4 5
HOW WOULD YOU RATE HIS/HER ATTITUDE?	1 2 3 4 5
REFERENCE	**TWO**
HOW WOULD YOU RATE HIS/HER WORK ETHICS?	1 2 3 4 5
HOW WOULD YOU RATE HIS/HER RELIABILITY?	1 2 3 4 5
HOW WOULD YOU RATE HIS/HER ATTITUDE?	1 2 3 4 5
REFERENCE	**THREE**
HOW WOULD YOU RATE HIS/HER WORK ETHICS?	1 2 3 4 5
HOW WOULD YOU RATE HIS/HER RELIABILITY?	1 2 3 4 5
HOW WOULD YOU RATE HIS/HER ATTITUDE?	1 2 3 4 5

Signs and Symptoms of TB (tuberculosis).

Visit www.cdc.gov/tb/signs-symptoms/index.html

KEY POINTS

- Symptoms of active tuberculosis (TB) disease depend on where the TB germs are growing in the body.
- Common symptoms of active TB disease include cough, pain in the chest, and coughing up blood or sputum (phlegm).
- People with inactive TB, also called latent TB infection, do not have symptoms of TB disease and cannot spread TB to others.

Active TB Disease

Symptoms of active TB disease depend on where in the body the TB germs are growing. TB germs usually grow in the lungs (pulmonary TB).

Active TB disease in the lungs may cause symptoms such as:

- A bad cough that lasts 3 weeks or longer
- Pain in the chest
- Coughing up blood or sputum (phlegm) from deep inside the lungs

Other symptoms of active TB disease are:

- Weakness or fatigue,
- Weight loss,
- No appetite,
- Chills,
- Fever, and
- Sweating at night.

Symptoms of active TB disease in other parts of the body depend on the area affected:

- TB disease of the lymph nodes may cause a firm red or purple swelling under the skin.
- TB disease of the kidney may cause blood in the urine.
- TB meningitis (TB disease of the brain) may cause headache or confusion.
- TB disease of the spine may cause back pain.
- TB disease of the larynx may cause hoarseness.

Please check any signs or symptoms you may be experiencing and return this to Better is Better, LLC Home Care Agency with your signature & date

Questionnaire:

Date:_____

Location (Monessen, Washington, Greensburg): _____

Full Name Printed Neatly: _____

Please circle the most accurate response:

1. Have you experienced any of the following symptoms in the past year?

a.) A productive cough for more than 3 weeks?	**Yes**	**No**
b.) Hemoptysis (coughing up blood)?	**Yes**	**No**
c.) Unexplained weight loss?	**Yes**	**No**
d.) Fever, Chills, or night sweats for no known reason?	**Yes**	**No**
e.) Persistent shortness of breath?	**Yes**	**No**
f.) Unexplained fatigue?	**Yes**	**No**
g.) Chest Pain?	**Yes**	**No**

2. Have you had contact with anyone with active tuberculosis disease in the past year? **Yes** **No**

3. Do you have a medical condition, or are you taking medications, which suppress your immune system? **Yes** **No**

I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

Signature_____ _____ **Date**_____

52.21 Staff Training

Better is Better LLC will comply with chapter 52.21. Staff Training

(a) A provider shall meet the training requirements necessary to maintain appropriate licensure or certification, or both, in addition to meeting the training requirements of this chapter.

(b) Prior to providing a service to a participant, a staff member shall be trained on how to provide the service in accordance with the participant's service plan.

(c) A provider shall maintain documentation for the following:

(1) Staff member attendance at trainings.

(2) Content of trainings.

(d) A provider shall implement standard annual training for staff members providing services which contains at least the following:

(1) Prevention of abuse and exploitation of participants.

(2) Reporting critical incidents.

(3) Participant complaint resolution.

(4) Department-issued policies and procedures.

(5) Provider's quality management plan.

(6) Fraud and financial abuse prevention.

Better is Better home Care will implement a sign off form for staff training and participant service plan. Better is Better Home Care (BIBHC) will assign this responsibility to only the owner, office manager, and supervisor/service agent of the agency. BIBHC will monitor care training annually. BIBHC will attach this staff training chapter 52. 21 to dcw application. Dcw will sign this form during interview and annually to ensure dcw is trained properly.

Print name:_____

Signature:_____ _____

NEW EMPLOYEE HIPAA EDUCATION
HANDOUT
REVISED 4.5.25

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 establishes federal standards protecting sensitive health information from disclosure without patient's consent. The US Department of Health and Human Services issued the HIPAA Privacy Rule to implement HIPAA requirements. The HIPAA Security Rule protects specific information cover the Privacy Rule.

With limited exceptions, the HIPAA Privacy Rule (the Privacy Rule) provides individuals with a legal, enforceable right to see and receive copies upon request of the information in their medical and other health records maintained by their health care providers and health plans.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal law that protects patients' sensitive health information from being disclosed without their consent. HIPAA laws include:

- **Privacy Rule**: Limits who can access and receive a patient's health information, and how it can be used. Patients have the right to request copies of their medical records and other health information.
- **Security Rule**: Protects specific information covered by the Privacy Rule.
- **Confidentiality, integrity, and availability**: Covered entities such as Home Care Agencies must meet these rules in health care.

HIPAA protects information that can identify a patient, such as health records, lab reports, bills, and verbal conversations. HIPAA violations include:

- Unauthorized access, use, or disclosure of protected health information (PHI)
- Failure to provide patients with access to their PHI
- Lack of safeguards to protect PHI
- Failure to conduct regular risk assessments

1. The HIPAA Privacy Rule (Who Can Look at and Receive Your Health Information)

The Privacy Rule sets rules and limits on who can look at and receive your health information. To make sure that your health information is protected in a way that does not interfere with your health care, your information can be used and shared:

- For your treatment and care coordination
- To pay doctors and hospitals for your health care and to help run their businesses
- With your family, relatives, friends, or others you identify who are involved with your health care or your health care bills, unless you object
- To make sure doctors give good care and nursing homes are clean and safe
- To protect the public's health, such as by reporting when the flu is in your area
- To make required reports to the police, such as reporting gunshot wounds

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, **your provider generally cannot:**

- **Give your information to your employer**
- **Use or share your information for marketing or advertising purposes or sell your information**

2. The HIPAA Security Rule

The HIPAA Security Rule sets out the minimum standards for protecting electronic health information (ePHI). To access that information in electronic format, even those who are technically capable of doing so would have to meet those standards.

The HIPAA security rule covers the following aspects:

- The organizations that may need to follow the security rule and be deemed covered entities.
- Safeguards, policies, and procedures that can be put in place to meet HIPAA compliance
- Health care information that is under the protection of the security rule

To put it simply, anyone who is part of the BA or CE and can access, alter, create or transfer recorded ePHI will be required to follow these standards. These technical safeguards will involve NIST-standard encryption in case the information goes outside the firewall of the company.

In addition to technical safeguards, the security rule will include several physical safeguards. If you're in a public area, you won't be able to see the screen because of a workstation layout. Only a specific area within the company's network allows you to do this.

Administrative safeguards are also checked, and they are combined with the security rule and the privacy rule. A privacy officer and a security officer are required to conduct regular (an ongoing process) audits and risk analyses as part of these safeguards.

These evaluations are critical to the safety of the system. When considering possible threats to the PHI, they don't care if it's just a theory. Consequently, they plan to implement a risk management plan based on it to avoid any potential risks that could occur in the future.

A covered entity must take the following steps to ensure the security of all ePHI they create, send, or receive:

- Ensure the confidentiality integrity and availability of the PHI
- Protect against improper uses and disclosures of data
- Protect the ePHI against potential threats, safeguarding their medical records
- Train employees so that they are aware of the compliance factors of the security rule
- Adapt the policies and procedures to meet the updated security rule

Confidentiality, integrity, and availability rules in health care must be met by the covered entity.

3. The HIPAA breach notification rule

Occasionally, there may be a breach. The breach notification rule comes into play here. The Department of Health and Human Services must be informed as soon as possible if there has been a data breach. Regardless of the nature of the breach, this must be done within 60 days of its discovery, this is where a good risk management plan comes in handy.

If a breach during administrative actions involves an individual's personal information, that person must be notified within 60 days of the discovery of the breach.

Protected health information (PHI) cannot be shared under HIPAA.

What exactly is considered PHI according to HIPAA? It's information that can identify a particular patient, including health records, lab reports, bills, or even verbal conversations. Here are specific examples of both physical and electronic PHI that cannot be shared under HIPAA.

- Healthcare claims
- Documentation of doctor's visits
- Payment and remittance information
- Coordination of healthcare benefits
- Claim status
- Health claims attachments
- Enrollment information in a health plan
- Eligibility information for health plans
- Injury reports
- Personal information generated from premium payments
- Details from electronic funds transfers (EFT)

FREQUENTY ASKED QUESTIONS

What is a HIPAA Violation?

A HIPAA violation refers to the failure to comply with HIPAA rules, which can include unauthorized access, use, or disclosure of Protected Health Information (PHI), failure to provide patients with access to their PHI, lack of safeguards to protect PHI, failure to conduct regular risk assessments, or insufficient workforce training on the HIPAA rules.

Under what circumstances can HIPAA be broken without patient consent?

HIPAA can be broken without patient consent in several circumstances, including for public health activities, law enforcement purposes, cases of abuse or neglect, organ donation processes, research (with IRB approval), workers' compensation claims, and emergencies where there is a serious threat to health or safety. These exceptions are designed to protect public interests and ensure effective healthcare delivery.

How does HIPAA address disclosures to family members or others involved in a patient's care?

HIPAA allows healthcare providers to disclose PHI to family members or others involved in a patient's care if the patient does not object. If the patient is not present or incapacitated, providers can share information if they determine that it is in the patient's best interest based on professional judgment. This includes instances like notifying family members of a patient's location, condition, or death.

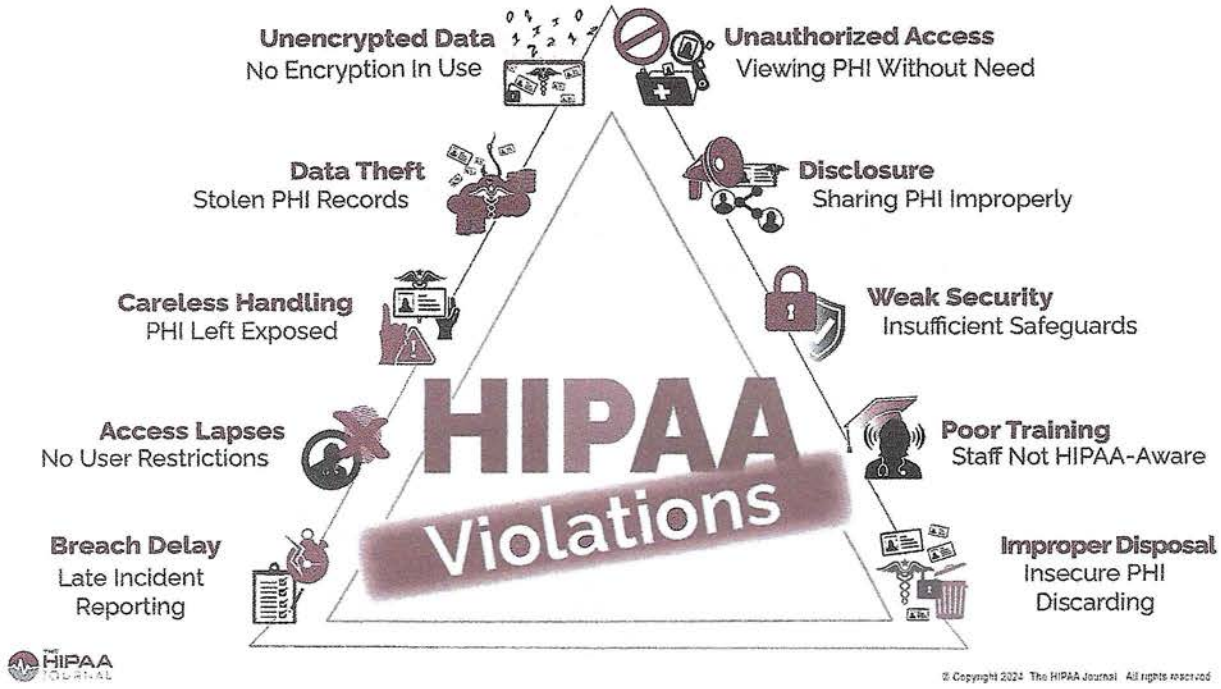
Are there any situations where HIPAA permits the use of PHI for health oversight activities?

Yes, HIPAA allows the use and disclosure of PHI for health oversight activities authorized by law. This includes audits, investigations, inspections, licensure, or disciplinary actions necessary for oversight of the healthcare system, government benefit programs, and regulatory compliance.

Can healthcare providers share PHI with other providers for continuity of care?

Yes, HIPAA permits healthcare providers to share PHI with other healthcare providers for treatment purposes without patient authorization. This includes consultations between providers or referrals to specialists, ensuring continuity and coordination of care for the patient.

What protections does HIPAA have in place when disclosures are made under its exceptions?
HIPAA requires that any disclosure of PHI under its exceptions must be the minimum necessary to accomplish the intended purpose. Covered entities must also take reasonable steps to safeguard PHI and limit access to those who need it for the specified purpose. Additionally, specific conditions and safeguards are often required for certain types of disclosures, such as obtaining an IRB waiver for research purposes.



Consequences of violating the HIPAA Privacy Rule for CEs:

- Risks Our Position of Trust: Trust involves keeping the client's personal health information private.
- Confidentiality Breach: Caregivers have access to sensitive medical records and protected health information. They should only share this information with those directly involved in the client's healthcare. Chart notes and records should remain within the care team.
- Reputational Damage: Violations can harm the caregiver's reputation and trustworthiness.
- Jail Time: In severe cases, criminal violations may lead to imprisonment.
- Sanctions: The caregiver could face professional sanctions or penalties.
- Loss of License: A serious violation might result in losing their license to practice.
- Fines: Civil fines range from $100 to $50,000 per violation.

NEW EMPLOYEE HIPAA EDUCATION
HANDOUT
REVISED 4.5.25

I, _____, on this day,
_____

have received, discussed, been given a copy for my onboarding/ annual training HIPAA document, and understand the law as pertains to HIPAA federal, state and Better is Better, LLC Home Care Agency compliances. I further understand and have been notified of all potential HIPAA violation responses including legal actions, employment actions, and personal professional fines.

Signature and date: _____.
_____

I agree to adhere to all HIPAA requirements, especially understanding the proper way to handle all documents, images, and forms pertaining to the rights for privacy and security of all clients of the Better is Better Home Care Agency.

Signature and date: _____.
_____

I, _____, on this day,
_____ agree to never send client information, including any forms or images, via unsecured electronic or physical means. I understand that secured means would include sending via encryption and have been trained on how to execute such encryption.

Signature and date: _____.
_____

Supervisor Name: _____

Training Conducted by: _____

Date of Training: _____

Better is Better, LLC Home Care Agency
90-Day Probationary Period Policy

This information is critical to understand in full. All questions prior to signing the agreement are invited. This Probationary Policy will immediately be in effect for all new and rehire employees and may also be placed in effect for any employee as a direct result of repeat incident reporting as it pertains to his/her employee file.

Initials, signature, and date of document will represent thorough understanding, agreement, and adherence to the 90-day Probationary Period Policy.

The 90-day Probationary Period is intended to supply any employee the opportunity to demonstrate his/her ability to achieve and maintain a satisfactory level of performance as measured by the hiring position job description. Better is Better, LLC Home Care Agency will use this period to evaluate the employee performance and need for any further training or support, which may affect pay.

If in agreement, initial here____

Pennsylvania is an "At-will" state which gives Better is Better, LLC Home Care Agency the right to end employment for any employee any time during or after the probationary period with or without cause or advance notice.

If in agreement, initial here_____

A 90-day Probationary Period begins on the first day of hire, after all required documents, third-party affiliations, background checks (state or federal) and Tuberculosis Screening #1 are complete. A 90-day Probationary Period may also begin on the day a determination is made regarding need for additional training, a suspension is lifted, or as a direct result of repeat incident reporting.

If in agreement, initial here_____

Employee absences without third-party Professional documentation (ex: letter from school for sick child) during the 90-day Probationary Period, will result in a proportional extension of the probationary period.

If in agreement, initial here_____

Better is Better, LLC Home Care Agency reserves the right to extend or reinstate a 90-day Probationary Period after written explanation of the determination.

If in agreement, initial here_____

All new, rehired, or "under-probation" employees are required to inform Better is Better, LLC Home Care Agency ***in writing*** (texting excluded), of any known conflicts for scheduling of hours/shifts during the 90-day probationary period. This information must be conveyed during the interview or policy implementation process. "Calling off", shift-switching, tardiness, undocumented failure-to-report-to-work, giving notice or quitting are grounds for termination at a pay reduction for all work hours earned during the 90-day Probationary Period at slightly above Pennsylvania minimum wage requirements (currently $7.50/hr by this Agency). Better is Better, LLC Home Care Agency reserves the right to withhold payroll earnings if overpayment, in compliance of this agreement, is found.

If in agreement, initial here_____

Better is Better, LLC Home Care Agency will assign an administrative coordinator to support all new, rehire, and under-probation employees for thorough training of state, federal, and agency regulations. However, the responsibility is on the employee to learn, revisit, adhere to, and reach out for clarification and/or additional training of all policies and regulations.

If in agreement, initial here_____

Employment

Position:_____ Signature

of Employee:_____

Signature of Witness (administrator):_____

Date Signed:_____/_____/_____

DISCLOSURE AND AUTHORIZATION REGARDING BACKGROUND INVESTIGATION FOR EMPLOYMENT PURPOSES

Disclosure

Better is Better, LLC (the "Company") may request from a consumer reporting agency and for employment-related purposes, a "consumer report(s)" (commonly known as "background reports") containing background information about you in connection with your employment, or application for employment, or engagement for services (including independent contractor or volunteer assignments, as applicable).

HireRight, LLC ("HireRight") will prepare or assemble the background reports for the Company. HireRight is located and can be contacted at 3349 Michelson Drive, Suite 150, Irvine, CA 92612, (800) 400-2761, www.hireright.com.

The background report(s) may contain information concerning your character, general reputation, personal characteristics, mode of living, or credit standing. The types of background information that may be obtained include, but are not limited to: criminal history; litigation history; motor vehicle record and accident history; social security number verification; address and alias history; credit history; verification of your education, employment and earnings history; professional licensing, credential and certification checks; drug/alcohol testing results and history; military service; and other information.

Authorization

I hereby authorize Better is Better, LLC to obtain the consumer reports described above about me.

Applicant Name_____

Applicant Signature_____ Date_____

ELECTRONIC VISIT VERIFICATION AGREEMENT. (EVV) IN COMPLIANCE WITH PA STATE LAW

ELECTRONIC VISIT VERIFICATION (EVV) through HHAeXchange

Direct Care Worker Agreement for

FEDERAL, STATE, AND AGENCY COMPLIANCE, DAILY SERVICE LOG (DSL), and PROPER CLOCK IN AND CLOCK OUT SYSTEM USE

*Section 12006 of the 21st Century CURES Act requires states to implement an EVV system for Medicaid-funded **Personal Care Services (PCS)** and for Home Health Care Services (HHCS). Additional information about the 21st Century CURES Act can be found on the Centers for Medicare and Medicaid Services (CMS) website and the EVV overview presentation.*

What Information Must the EVV System Collect?

The CURES Act requires that EVV systems must collect and verify the following:

1. *The type of service provided.*
2. *The name of the individual receiving service.*
3. *The date of service delivery.*
4. *The location of service delivery.*
5. *The name of the individual providing the service.*
6. *The time the service begins and ends.*

The 21st Century Cures Act is a United States law enacted by the 114th United States Congress in December 2016 and then signed into law on December 13, 2016.

In compliance with PA State and Federal Laws regarding CURES Act regulation, ALL direct care workers (DCWs) *must use HHAeXchange* (our third-party vendor) when providing personal home care services for customers (clients) of Better is Better, LLC Home Care Agency. Failure to comply is cause for employment actions to include placement into the Agency's Probationary Period status with all the 90-day probationary agreements in place until 100% EVV compliance is achieved and maintained, roster removal meaning that no hours will be assigned to the non-compliant DCW until re-training has occurred, or termination for any appearance of repeat or willful defiance.

ACTION PLAN FOR HHAeXchange COMPLIANCE:

1. DCWs are required to own a smart phone device in good working order, fully charged and connected to a good signal while on-site with client.
2. DCWs are required to download and maintain the HHAeXchange app.
3. DCWs must be registered with HHAeXchange.
4. The HHAeXchange 7-digit code must be registered with Better is Better, LLC Home Care Agency to remain in the DCW employee file. This number links and tracks the DCW in the EVV system.
5. DCWs will be given a schedule to follow on the HHAeXchange app. This is the work schedule assigned by the Case and/or Office Manager of Better is Better, LLC Home Care Agency.

ELECTRONIC VISIT VERIFICATION AGREEMENT. (EVV) IN COMPLIANCE WITH PA STATE LAW

CLOCK IN and CLOCK OUT COMPLIANCE:

1. During scheduled or "sub-in" shifts, direct care worker must: *Clock in* ***inside participant's home,*** *Clock out* ***inside participant's*** *home, Check "off duty".*
2. An approved "Incident Report" with visual (screenshot or video) evidence submitted to the Case and/or Office Manager must be completed for any manual override of the EVV to be completed.
3. Regular (more than once each quarter—3 month period) request for manual override of the EVV system by DCWs may result in non-payment of hours worked (see EVV PA state auditing: https://www.pa.gov/agencies/dhs/resources/for-providers/evv/evv-pcs.html).
4. Better is Better, LLC Home Care Agency is aware of "spotty" internet issues with regard to HHAeXchange interactions. Please be able to provide proof by screenshot of no signal or of HHAeXchange screen message.
5. Signing onto a client's internet is acceptable with as some written form of approval from the client submitted to case manager and/or office manager of Better is Better, LLC Home Care Agency.

DAILY SERVICE LOG COMPLIANCE:

1. Better is Better, LLC Home Care Agency requires ALL DCWs to properly submit the ***Daily Service Log***; a service checklist agreement *shift tracker*.
2. DCWs are required to use the tracker during every scheduled or "sub-in" shift.
3. The Daily Service Logs generated by DCWs must be submitted to and collected by case managers and/or office managers monthly.
4. These trackers will be collected every month on or before a date set by the office manager.
5. DCWs must
    - Checkmark services provided during the shift
    - Verify clock-in and clock-out date/time
    - Signature of DCW required with date of signature
    - Customer (client) signature and date of signature
    - Properly comply with HIPAA regulations when being in possession of or handing over Daily Service Log forms to Better is Better, LLC Home Care Agency personnel
6. DCWs are mandated reporters of abuse, neglect, behavioral health concern, physical health concern. Daily Service Logs should also include any reporting of concern.
7. Concerns which seem to be of an Urgent or Emergency nature should bypass the Daily Service Log to be reported immediately.

DCWs are prohibited from:

1. Using a different device for logging into and interacting with the EVV system through HHAeXchange is prohibited without informing the case manager and/or office manager of a new device.
2. Leaving customer (client) during a shift for any reason—including but not limited to errand-running.
3. Purchasing alcohol, vapes, drugs, or any form of tobacco for anyone, especially a customer (client), while clocked-in.

ELECTRONIC VISIT VERIFICATION AGREEMENT. (EVV) IN COMPLIANCE WITH PA STATE LAW

4. Taking possession of (for any amount of time) a customer's (client's) monetary agents such as ATM cards, checks, credit cards, money orders, etc.

Failure to maintain compliance of the CURES Act, PA State Department of Health Rules and Regulations, or the internal Policy and Procedure Guidelines set by Better is Better, LLC Home Care Agency may result in immediately termination, unpaid leave during investigation, or leave during re-training of the laws, regulations, and policies which are mandatory to understand within the Home Care Industry.

I, _____ understand the lawful requirements for Electronic Visit Verification compliance. I confirm that I have been invited to ask questions for clarification of these requirements, have been presented this document for discussion and comprehension and agree to full compliance as required for my position as

_____ at _____ location.

Employee Name_____

Employee Signature_____

Administrator Name_____

Administrator Signature_____

Date_____

Better is Better Home Care

Direct Care worker Requirements

All direct care work who is staff with Better is Better will complete a competency exam for personal home care. Direct care worker must complete and pass with an 80% or higher in order to begin services. What this means is that when you work with residents who behave in potentially dangerous ways, there are some effective things you can do to ensure their safety as well as your own. All direct care worker must provide a tuberculosis screening of exam. All staff and direct care worker must pass criminal background check. If there is a child present, we will perform a child abuse clearance check for the direct care worker.

- **Bathing**
- **Shaving**
- **Grooming**
- **Dressing**
- **Hair**
- **Transferring**
- **Feeding**
- **Toileting**
- **Laundry**
- **Ambulation**
- **Meal preparation**
- **Mouth**
- **Skin**
- **Housekeeping**
- **Errand**
- **Companionship**

CLGS-32-6 (8-11)

RESIDENCY CERTIFICATION FORM
Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change.

EMPLOYEE INFORMATION - RESIDENCE LOCATION			
NAME (Last Name, First Name, Middle Initial)			SOCIAL SECURITY NUMBER
STREET ADDRESS (No PO Box, RD or RR)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	RESIDENT PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION - EMPLOYMENT LOCATION			
EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (No PO Box, RD or RR)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	WORK LOCATION PSD CODE		WORK LOCATION NON-RESIDENT EIT RATE

CERTIFICATION	
Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.	
SIGNATURE OF EMPLOYEE	DATE (MM/DD/YYYY)
PHONE NUMBER	EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com

6

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly or Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

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

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . 3 $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

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

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

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

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

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $

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

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

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

1 Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $

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

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

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

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

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

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

COMMONWEALTH OF PENNSYLVANIA

New Hire Reporting Form

Required Employer Information

FEIN:

Employer Name:

Address:

Contact Name:

Contact Phone #:

Please mail or fax to:

Commonwealth of Pennsylvania
New Hire Reporting Program
P. O. Box 69400
Harrisburg, PA 17106-9400

Fax: 717-657-HIRE (717-657-4473)

Phone: 1-888-PAHIRES (1-888-724-4737)
(for questions only)

This form can be duplicated

Required Employee Information *(Please type or print legibly in black or blue ink.)*

Employee Social Security # | Date of Birth (mm/dd/yyyy) optional | Date of Hire (mm/dd/yyyy)

Name (first) | (middle) | (last)

Address

City | State | Zip

Employee Social Security # | Date of Birth (mm/dd/yyyy) optional | Date of Hire (mm/dd/yyyy)

Name (first) | (middle) | (last)

Address

City | State | Zip

Employee Social Security # | Date of Birth (mm/dd/yyyy) optional | Date of Hire (mm/dd/yyyy)

Name (first) | (middle) | (last)

Address

City | State | Zip

New Hire Reporting

Lending a Hand to Pennsylvania's Children

Commonwealth of Pennsylvania | Department of Labor and Industry | Center for Workforce Information and Analysis

Pennsylvania New Hire Reporting Program - 5

NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER SECTION 306 (f.1)(1)(i) OF THE PA. WORKERS' COMPENSATION ACT

The Pennsylvania Workers' Compensation Act requires that employees be given written notification of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. Below are your rights and duties under Sec. 306 (f.1)(1)(i) and an acknowledgment signature line. This acknowledgment, signed by you, is to be returned to your employer.

A brief summary: You have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that your employer is not liable for the medical bills incurred.

As an employee of the Commonwealth working at a location where a list of designated health care providers has been established and posted, you have:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties
under Sec. 306 (f.1)(1)(i) and that I understand them
to the extent that they are explained above.

Print Name _____ Employee Signature _____ Date _____

See reverse for a complete text of Section 306 (f.1)(1)(i)
If you have any questions, ask your human resources office representative or call
The Bureau of Workers' Compensation at 1-800-482-2383

Employment Eligibility Verification

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

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

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the instructions.

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

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

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

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)

If you check Item Number 4., enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

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

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

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

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.	First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: 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 individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central. The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.
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		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on I-9 Central for more information.

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

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

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

Last Name (Family Name) from Section 1.	First Name (Given Name) from Section 1.	Middle initial (if any) from Section 1.

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial *(if any)* from **Section 1.**

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

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

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

Document Title	Document Number (if any)	Expiration Date (if any) (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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

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

Document Title	Document Number (if any)	Expiration Date (if any) (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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

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

Document Title	Document Number (if any)	Expiration Date (if any) (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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

PAYCHEX

Payroll • HR • Retirement • Insurance

Employee Information Worksheet

1. First Name _____
2. Middle Initial_____
3. Last Name _____
4. Street Address _____
5. City_____
6. State_____
7. Zip Code _____
8. Rate of Pay_____
9. Social Security Number _____-_____-_____
10. Date of Hire _____/_____/_____
11. Marital Status: Married _____ Single _____
12. Number of Exemptions: Federal _____ State _____
13. Birthdate _____/_____/_____

PAYCHEX

Direct Deposit Enrollment/Change Form*

Company Name and/or Client Number _____

Employee/Worker Name_____ **Employee/Worker Number** _____

EMPLOYEE/WORKER: Retain a copy of this form for your records. Return the original to your employer/company.

EMPLOYER/COMPANY: Return this form to your local Paychex office. For clients using on-line services, please retain a copy of this document for your records.

COMPLETE TO ENROLL / ADD / CHANGE BANK ACCOUNTS – *PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY*

Type of Account: ☐ Checking ☐ Savings | Accountholder's Name:

Routing/Transit Number ☐☐☐☐☐☐☐☐☐

Checking/Savings Account Number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Financial Institution ("Bank") Name

I wish to deposit (check one): ☐ _____% of Net ☐ Specific Dollar Amount $ _____.00 ☐ Remainder of Net Pay

Type of Account: ☐ Checking ☐ Savings | Accountholder's Name:

Routing/Transit Number ☐☐☐☐☐☐☐☐☐

Checking/Savings Account Number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Financial Institution ("Bank") Name

I wish to deposit (check one): ☐ _____% of Net ☐ Specific Dollar Amount $ _____.00 ☐ Remainder of Net Pay

COMPLETE IF CHANGING EXISTING DEPOSIT AMOUNTS – *PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY*

Type of Account: ☐ Checking ☐ Savings | Accountholder's Name:

Routing/Transit Number ☐☐☐☐☐☐☐☐☐

Checking/Savings Account Number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Financial Institution ("Bank") Name

I wish to change my deposit amount to (check one): ☐ From _____% to____% of Net ☐ From $_____.00 To $_____.00
☐ Remainder of Net Pay

EMPLOYEE/WORKER CONFIRMATION STATEMENT

PLEASE SIGN IN BLACK/BLUE INK ONLY

I authorize my employer/company to deposit my earnings into the bank account(s) specified above and, if necessary, to electronically debit my account to correct erroneous entries. I certify my account(s) allow these transactions. Furthermore, I certify that the above listed account number accurately reflects my intended receiving account. I agree that direct deposit transactions I authorize comply with all applicable laws. My signature below indicates that I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer/company to make direct deposits into the named account.

Employee/Worker Signature _____ **Date** _____

Note: Digital or Electronic Signatures are **not** acceptable.

I confirm that the above named employee/worker has added or changed a bank account for direct deposit transactions processed by Paychex, Inc. I have reviewed the information provided and it is accurate to the best of my knowledge. My signature below indicates that I have the authority to execute this document on behalf of the Client.

Employer/Company Representative Printed Name: _____

Employer/Company Representative Signature:_____ **Date:**_____

*** All fields are required except Employee/Worker Number.**

**** Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.**

DP0002 10/17
Form Expires 10/31/20