Application for Employment

We are an equal opportunity employer, and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability status, protected veteran status, or any other characteristic protected by law.

Applicant Name (last, first, middle): _____

Email Address: _____

Current Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Name / Address of next of kin: _____

Are you at least 18 years old? ❑ Yes ❑ No

Position Applying For: _____

❑ Full time ❑ Part time ❑ Part time per visit ❑ Pool

Shift: ❑ Day ❑ Evening ❑ Night ❑ Weekends

If you are not a US citizen, do you have the legal right to remain permanently in the US? ❑ Yes ❑ No

Salary Requirements: _____ Date Available: _____

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

Educational History

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

List professional licenses you possess. Indicate type (i.e., license, certification, registration, etc.), number, and issuing state:

_____

_____

_____

List any memberships in professional organizations, honors, or activities which you feel would enhance your application, excluding those that would indicate race, color, religion, sex, national origin, disability status, protected veteran status, or any other characteristic protected by law:

_____

_____

Application for Employment

Name: _____

List languages spoken other than English:

_____

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

_____

_____

Work History

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

Company Name	Complete Address including city, state, zip	Phone Number	Supervisor's Name
Date Started Date Left	Type of Business ❑ Full time ❑ Part time ❑ Per visit	Reason for Leaving	Ok to Contact Supervisor ❑ Yes ❑ No
Describe your job title, responsibilities, and accomplishments: _____ _____ _____			
Company Name	Complete Address including city, state, zip	Phone Number	Supervisor's Name
Date Started Date Left	Type of Business ❑ Full time ❑ Part time ❑ Per visit	Reason for Leaving	Ok to Contact Supervisor ❑ Yes ❑ No

Application for Employment

Name: _____

Describe your job title, responsibilities, and accomplishments:

_____

_____

_____

Company Name	Complete Address including city, state, zip	Phone Number	Supervisor's Name
Date Started Date Left	Type of Business ❑ Full time ❑ Part time ❑ Per visit	Reason for Leaving	Ok to Contact Supervisor ❑ Yes ❑ No

Describe your job title, responsibilities, and accomplishments:

_____

_____

Personal References – Name, Phone, Relationship:

_____

_____

Emergency Contact: _____

Relationship: _____ Phone: _____

Address: _____

Out-of-State Contact (if possible): _____

Relationship: _____ Phone: _____

Address: _____

Application for Employment

Please review and sign

In making application for employment:

- I certify that the information in this application is true and complete for all practical purposes. It may be verified by the Agency or any affiliate. Should a position be offered and later it is found that the information is significantly untrue, incomplete, or misrepresented, I understand and agree that the Agency or its affiliates are relieved of all commitments, financial or otherwise pertinent to employment, and that I am subject to immediate termination without recourse.
- I understand and agree that if I am offered employment by the Agency, my employment will be for no definite term and that either I, or the Agency will have the right to terminate the employment relationship at any time, with or without cause, and with or without notice. I also understand that this status can only be altered by a written contract of employment which is specific as to all material terms and is signed by me and the Administrator of the Agency.
- I understand, if I have direct patient contact that the Agency will perform a background check, including criminal history check, OIG exclusion list check (if applicable), and any additional checks as required by accrediting body standards or State Regulations. I further understand, if I am an unlicensed person, the Agency will perform a check of the Nurse Aide Registry and Employee Misconduct Registry. I understand that: 1) the purpose of the Employee Misconduct Registry is to ensure that unlicensed personnel who commit acts of abuse, neglect, exploitation, misappropriation, or misconduct against residents and consumers are denied employment in HHS-regulated facilities and agencies; 2) the State of Texas maintains a registry of all nurse aides who are certified to provide services in nursing facilities and skilled nursing facilities licensed by the Texas Health and Human Services (HHS) and they review and investigate allegations of abuse, neglect, or misappropriation of resident property by nurse aides and if there's a finding of an alleged act of abuse, neglect, or misappropriation, the nurse aide may request both an informal reconsideration and a formal hearing before the finding is placed on the registry; 3) All HHS-regulated facilities and agencies are required to check the Employee Misconduct Registry and Nurse Aide Registry before hire to determine if I am listed in either registry as having committed an act of abuse, neglect, exploitation, misappropriation, or misconduct against a resident or consumer and am, therefore, unemployable. I understand that a refusal to authorize the criminal background check may result in adverse employment action, such as rejection of the application or termination of employment.

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

Applicant Signature: _____ Date: _____

FOR OFFICE USE ONLY	❑ Interview(s)	❑ References Checked	If Hired: Position: Start Date: Salary: ❑ Full time ❑ Part time ❑ Per visit

Reference Request

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

Name of person giving reference: _____

Facility: _____

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

Thank you in advance (name of representative): _____

Applicant Release

Last Name, First, Middle: _____

Maiden/Alias (if applicable): _____ Dates Employed: From _____ To _____

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

Applicant Signature: _____ Date: _____

---

1. Please confirm the applicant's employment dates: From _____ To _____
2. Please comment on the applicant's attributes using the provided scale:

Quality of Work:	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Knowledge & Skills:	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Reliability & Attendance:	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Cooperation:	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Competence:	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Supervisory Ability & Capacity:	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
Grooming:	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable

3. Please indicate specialty areas in which the applicant has had experience: _____
4. Please indicate any special considerations necessary when giving assignments to this individual:

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

   _____

Please attach any additional comments.

Signature: _____

Position/Title: _____ Date: _____

Reference Request

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

Name of person giving reference: _____

Facility: _____

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

Thank you in advance (name of representative): _____

Applicant Release

Last Name, First, Middle: _____

Maiden/Alias (if applicable): _____ Dates Employed: From _____ To _____

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

Applicant Signature: _____ Date: _____

---

1. Please confirm the applicant's employment dates: From _____ To _____
2. Please comment on the applicant's attributes using the provided scale:

Quality of Work:	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable
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Grooming:	4 = Excellent	3 = Good	2 = Fair	1 = Poor	N/A = Not applicable

3. Please indicate specialty areas in which the applicant has had experience: _____
4. Please indicate any special considerations necessary when giving assignments to this individual:

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

   _____

Please attach any additional comments.

Signature: _____

Position/Title: _____ Date: _____

Employee Acknowledgment

Confidentiality: The Agency maintains confidentiality of operations, activities, and business affairs of the Agency and the patients/clients according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Texas Medical Records Privacy Act-Texas Health and Safety Code Chapter 181 (HB300). Due to the nature of our work, each employee will gain, directly or indirectly, sensitive and confidential information on patients/clients and staff members. The healthcare professional safeguards the patient's/client's right to privacy by judiciously protecting information of a confidential nature including medical treatment information, diagnosis, medical records, personal patient/client information, etc. This information should be shared only with those persons whom, due to position, have a need to know. Sensitive or confidential information must never be used as the basis for social conversation or gossip. If an employee is in doubt as to whether certain information may be shared, the employee should consult with the supervisor.

Drug Testing Policy: The Agency maintains a Drug-Free Workplace Policy with regard to the possession, use, distribution, and sale of drugs or alcohol. All employees are prohibited from the unlawful or unauthorized manufacture, distribution, dispensing, possession, or use of a controlled substance or any alcoholic beverages while in the workplace or on company paid time. Violation of this policy can result in disciplinary action up to and including termination of employment. I acknowledge I have received of a copy of the Agency's policy on drug testing.

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

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

Non-Discrimination: The Agency does not discriminate against employees based on race, color, religion, sex, national origin, disability status, protected veteran status, or any other characteristic protected by law. The employee may file a report of a grievance or complaint regarding discrimination with the Office of Civil Rights within 180 days of when the employee knew of the situation.

Non-Discrimination: The Agency does not discriminate in patient/client provision of services with respect to race, color, national origin (including limited English proficiency and primary language), age, sex (as described in 45 CFR section 92.101(a)(2)), disability, basis of relationship or association, source of payment according to Title VI of the Civil Rights Act or any other characteristic protected by law.

Abuse, Neglect, and Exploitation: Agency employees will report suspected abuse, neglect, and/or exploitation to Agency management and state authorities per policy and regulations. Agency employees suspected of abuse, neglect, or exploitation will be suspended immediately, an investigation will be conducted, and if the investigation validates the claim, the employee will be terminated.

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

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

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

Employee Signature: _____ Date: _____

Hand Hygiene Competency Checklist

Staff Name: (Last, First):	Job Title:
Evaluator:	Date:
Type of Validation: ❑ Orientation ❑ Annual/Periodic Review ❑ Other:	

Skills	Competency		
	YES	NO	Comments
Hand Hygiene with Soap and Water:			
1. Identifies and gathers the appropriate supplies			
2. Wets hands with water using temperature that is comfortable			
3. Applies amount of product recommended by manufacturer to hands, and rubs hands together vigorously for at least 20 seconds, covering all surfaces of hands, fingers, and nail beds			
4. Rinses thoroughly with water			
5. With hands held upright, dries thoroughly with a clean paper towel			
6. Turns the faucet off using a dry paper towel to touch the handle, protecting clean hands from the contaminated handle			
Verbalizes and/or Demonstrates when Hand Hygiene is Indicated Using Soap & Water:			
1. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids			
2. Before eating and after using the restroom			
3. After known or suspected exposure to Clostridium difficile, infectious diarrhea during norovirus outbreaks, or Bacillus anthracis			
Hand Hygiene with Alcohol-Based (60-95%) Hand Rub:			
1. Applies product to palm of one hand, following manufacturer's recommendations regarding amount of product to use			
2. Rubs hands together, covering all surfaces of hands and fingers, until dry – approximately 20 seconds			
Verbalizes and/or Demonstrates when Hand Hygiene is Indicated:			
1. Prior to initial entry into the supply bag			
2. Before having direct contact with the patient/client			
3. After direct contact with the patient/client			
4. After contact with bodily fluids, excretions, mucus membranes, wound dressings, and used supplies (PPE)			
5. After known or suspected exposure to infections or infectious diseases			
6. Before handling or preparing medications			
7. Before moving from a contaminated body site to a clean body site on the same patient/client during patient/client care			

Hand Hygiene Competency Checklist

8. After having contact with inanimate objects, including medical equipment, in the patient's/client's environment			
9. Before contact with or the preparation of food and beverage items			
10. After removing gloves			

Signature of Staff:	**Date:**
Signature of Evaluator:	**Date:**

Personal Protective Equipment (PPE) Competency Checklist

Staff Name (Last, First):	Job Title:
Evaluator:	Date:
Type of Validation: ❑ Orientation ❑ Annual/Periodic Review ❑ Other:	

Donning and Doffing of Personal Protective Equipment (PPE)			
Skills	**Competency**		
	YES	**NO**	**Comments**
Identifies the proper PPE to gather and verbalizes all appropriate PPE is available at point of use			
Verbalizes proper steps in examining PPE for defects			
(PPE should ideally be put on outside of the home prior to entry. If unable to put on all PPE outside of the home, it is preferred that face protection (i.e., respirator and eye protection) be put on before entering home.) Demonstrates the ability to follow the proper sequence for donning PPE in the following order:			
1. Hand hygiene using hand sanitizer for 20 seconds, cleansing all parts of the hands, fingers, and nail beds.			
2. Dons gown: fully covering torso from neck to knees and arms to ends of wrists; wrap around back; tie/fasten in back of neck and waist.			
3. Dons N95 respirator while ensuring air-tight fit.			
4. Performs seal check.			
5. Dons face shield: placing over face and eyes; adjust to fit as need.			
6. Dons gloves to cover wrist of gown.			
7. Enters the patient home.			
(PPE should ideally be removed outside of the home and discarded after visit. If unable to remove all PPE outside of the home, it is preferred that face protection (i.e., respirator and eye protection) be removed only after exiting the home.) Demonstrates the ability to follow the proper sequence for doffing PPE in the following order			
1. Exits patient home.			
2. Doffs gloves: Grasp outside of glove with opposite gloved hand, peel off using glove in glove technique. Discards in appropriate waste container.			
3. Doffs gown: Untie lower ties first and upper last without contamination using arm cross method. Pull away from neck and shoulders, touching inside of gown. Folds or rolls into bundle and discards in appropriate waste container.			
4. Doffs mask/face shield: Grasp bottom, untie lower ties first and upper last, pulling up and away from head. Avoid touching front of mask/respirator. Discards in appropriate waste container or stores mask for reuse per policy.			

Personal Protective Equipment (PPE) Competency Checklist

5. Discards all PPE by placing in external trash can before departing location. PPE should not be taken from the home in staff vehicle.			
6. Performs hand hygiene using hand sanitizer.			

Signature of Staff:	**Date:**
Signature of Evaluator:	**Date:**

Compliance Pledge

Agency Name: American Family Connections,Inc.

(Complete upon hire and annually)

The undersigned is a current Governing Body member, owner, officer, director, or person who performs billing or coding functions on behalf of the Agency or an employee of the Agency. In that capacity, the undersigned hereby affirms that:

I have received the Agency Standards of Conduct, have had an opportunity to have questions regarding the Standards of Conduct answered, and agree to conduct myself in accordance with the same in all dealings with or on behalf of the Agency;

I have completed the Compliance Training and Education Program as required by the Agency's Compliance Program;

I am not aware of any actual or potential unreported activity by any person or entity acting for or in conjunction with the Agency which is known or believed by me to be in violation of any applicable federal or state law, rule, or regulation;

I understand the importance of compliance with applicable laws, rules, and regulations to the Agency, government, and third-party payers;

I understand that all Agency representatives are expected to report any suspected violations of these laws, regulations, or rules to the supervisor or the Compliance Officer. I understand that I must also report any suspected violations of the policies or the standards and procedures of the Program, and that I may anonymously report any suspected violations through the compliance drop box or the hotline number at _____.

I understand that conduct in accordance with the Agency's Compliance Program will be a condition of my continued relationship with the Agency. I understand that failure to comply with the Program may subject me to sanctions or discipline to include, but not be limited to, termination of employment and/or privileges; and

I am not currently, and have not been, subject to any criminal charge or conviction involving any government business nor any conviction, exclusion action, disciplinary action, debarment or proposed debarment, or loss or limitation of licensure, privilege, or employment as a result of any alleged violation of applicable state or federal law, rule, or regulation.

_____ _____

Signature Date

_____

Print Name/Title or Job Description

Confidentiality / Conflict of Interest Disclosure Statement

Agency: American Family Connections,Inc.

Confidentiality / Non-Disclosure of Company or Patient/Client Information:

Access to any confidential or proprietary information will be limited to the minimum required for the performance of duties as relates to each individual's job. Any confidential information created, received, maintained, used, disclosed, accessed, or transmitted in the performance of job duties will be maintained and protected from unauthorized disclosure.

The Health Insurance Portability and Accountability Act (HIPAA) ensures the patients'/client's right to privacy of protected health information (PHI) to be maintained at all times. Any information related to the care of patients/clients through the Agency will be held as confidential. All information, written or verbal, will only be disclosed to appropriate healthcare personnel, staff, those with a "need to know", or individuals the patient/client requests.

Conflict of Interest Disclosure Statement:

I acknowledge I have read the policy and procedure regarding conflict of interest and the procedure for disclosure. I understand that if I have an outside relationship that is personal, professional, or otherwise, with a patient/client, vendor, or potential business associate, I must disclose the nature of that relationship to my supervisor, or Administrator as soon as the relationship is established. I also understand that I forfeit any voting privileges, decision-making capacity, and input from any activities associated with said relationship.

❑ I have no conflict of interest to report.

❑ I, _____ as a staff member, Governing Body member, or member of any Advisory Committee, am providing the following disclosure of potential conflict of interest:

_____

_____

_____

Printed Name

_____ _____

Signature Date

Reported conflict of interest reviewed by the Governing Body with the following decision(s) made:

_____

_____

_____ _____

Governing Body Member Signature Date

Hepatitis B Vaccination

Due to occupational exposure to blood or other potentially infectious materials, you may be at risk for acquiring hepatitis B viral (HBV) infection. The vaccination series is available, at no cost, to you. Please indicate below acceptance or declination to receive the vaccine.

Hepatitis B is a bloodborne virus which can cause a range of symptoms from mild to serious, and possibly result in fatal liver damage to health care workers who become infected. The virus can be transmitted through contact with infectious fluids of a patient who has the hepatitis B virus. You may have been taught the concepts of Universal Precautions concerning safe patient/client care and the use of equipment to avoid unnecessary exposure.

The synthetic hepatitis B vaccine is derived from yeast cells. It is not composed of human blood or plasma. It is given as a series of three injections into the arm muscle at prescribed intervals (initial shot, one month later, and six months later). It has proven to be 80-90% effective in protecting against the disease. There may be hypersensitivity to the vaccine, and there may be soreness and swelling of the injection arm. Other side effects may occur at an incidence of under 3% of injections.

The vaccine will not be given to persons with known sensitivity to aluminum hydroxide, thimerosal, yeast, or the hepatitis antigen, and will only be given with your personal physician's recommendations in the cases of pregnancy or the presence of other infections of an immunosuppressive state. The vaccine does not grant 100% assurance of immunity.

Acceptance: I have read the above information describing the risks and benefits of receiving the vaccination. I understand that the decision to receive the vaccination series is mine and I wish to receive the hepatitis B vaccine.

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

Declination: ❑ I have been given the opportunity to be vaccinated for hepatitis B, at no charge to myself. I decline the vaccination series. I understand that by declining this vaccine, I continue to be at risk for acquiring hepatitis B. If I continue to have occupational exposure to blood or other potentially infectious material and decide I want to be vaccinated with hepatitis B vaccine, I may receive the vaccination series at no charge to me.

❑ I have already received the hepatitis B vaccine series at an earlier date. Select one:

❑ I am providing a copy of the record to the Agency.

❑ I am not providing a copy of the record to the Agency.

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date

HIPAA-PHI Protection Agreement

- I plan to utilize electronic documentation of patient/client care.
- I will ensure confidentiality and security of patient/client information by password protecting the device or program utilized.
- I agree to change the password at least quarterly or following a breach of security.
- I will not provide my password to anyone.
- I will use an electronic signature, if acceptable to payor source. Authentication will be available if requested by the Agency.
- I have been informed of the Agency's Medical Record Information Confidentiality Policy and Safeguarding Medical Record Content Policy, and I agree to abide by these policies.
- I have completed the required training on the Texas Medical Records Privacy Act-Texas Health and Safety Code Chapter 181, Section 181.001 (HB300) concerning protected health information as necessary and appropriate to carry out my duties for the Agency.

_____

Printed Name

_____ _____

Signature Date

Orientation Checklist

General Orientation

1. ❑ **Introduction**
   - Welcome
     - Home Health Overview
     - Agency Mission Philosophy
   - Overview of Agency
     - Organizational Chart
     - Scope of Services
     - Geographical Coverage
     - How to Access Agency Policies and Procedures

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

3. ❑ **Human Resources/Personnel Administration**
   - Personnel File Maintenance
   - Background Checks
   - Employee Education
   - Employee Performance
   - Employee Grievance/Complaint Resolution
   - Progressive Discipline

4. ❑ **Compensation**
   - Work Schedules/Time Records
   - Pay Checks/Deductions/Overtime/Holidays
   - Family Medical Leave Act (FMLA)
   - Jury Duty

5. ❑ **Safety/OSHA**
   - OSHA
   - Risk Management
   - Personal Safety
     - Driving Safety
     - Body Mechanics
   - Fire Safety Procedures
     - Office
     - Patient/Client Residence
   - Workplace Security
   - Workplace Safety
   - Workplace Violence Prevention Program
   - Exposure Control
     - Standard Precautions
     - Hepatitis B
     - Personal Protective Equipment (PPE)
     - Hazardous Waste
   - Infection Control
     - Hand Hygiene
   - Emergency Preparedness and Response
   - Equipment Safety/Maintenance
   - Patient/Client/Employee Occurrence/Violence
     - Incident Reports
   - Adverse/Inclement Weather

Clinical Orientation

6. ❑ **Professional Direct Care Staff**
   - Patient/Client Care Policies and Procedures
     - On-Call for Patient/Client Care
     - Alternative Communication
     - Advance Directives
     - Patient/Client Rights/Responsibilities
     - Medical Emergency Management
     - Change in Patient/Client Condition/ Verbal Orders
     - Abuse, Neglect, and Exploitation

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Orientation Checklist

- Pain
- Supplies and Medical Equipment
- Transfer/Discharge

Documentation
- Documentation Guidelines in Home Care
- Documentation to Support Medical Necessity

Agency Forms
- Medication Profile
- Care Coordination
- Communication Notes
- Progress/Summary/Team Conference Notes
- Transfer Summary
- Discharge Summary

7. ❑ Admission and Recertification

Criteria for Admission
Criteria for Medicare Coverage
Admission Process
Documentation
- Consent Form
- Comprehensive Assessment
- Advance Directives
- Home Safety Assessment
- Medication Profile
- Plan of Care (POC)
- Home Health Aide Care Plan
- Recertification Process
- Recertification Documentation

8. ❑ OASIS Data Collection

Introduction
Conventions (rules) for Completing OASIS

9. ❑ Skilled Nursing Services

Medicare Coverage Criteria for Nursing
Case Management
Nursing Clinical Progress Note
Medication Safety and Compliance
Care of the Dying Patient/Client

10. ❑ Therapy Services

Medicare Coverage Criteria for Therapy
Assessment/Evaluation
Goals
Medical Equipment
Therapy Progress Note

11. ❑ Medical Social Services

Medical Social Services Coverage Criteria
Social Worker Requirements

12. ❑ Home Health Aide Services

Introduction
- Goals of Home Health Care
- General Guidelines
- In-Services
- Professional Conduction
- Patient/Client Rights
- Confidentiality

Communication Skills
- Guidelines for Effective Communication
- Barriers to Effective Communication

Provision of Care
- Home Health Aide Care Plan
- Home Health Aide Visit Note
- Reporting Patient/Client Observations
- Guidelines for Charting
- Approved Medical Abbreviations
- Communication Note
- Tips for Time Management
- Supervision of Aide Services

Safety
- Personal/Equipment/Oxygen/Bathroom
- Life Threatening Emergency Guidelines
- Abuse, Neglect, and Exploitation
- Exposure Control/Work Practice Controls
- Cleaning Equipment

Death and Dying
- Overview
- Death and Dying Summary Sheet

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Orientation Checklist

13. ❑ State Specific Orientation Information

State Orientation Manual

❑ Tour of Office

Medical Supplies

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Statement of Employability

By execution of this document, I acknowledge that I have been informed by the Agency and agree that the Agency may conduct a State of Texas criminal history check per Texas H&SC 250.006. I agree to a search of the Nurse Aide Registry and the Employee Misconduct Registry prior to employment and at least every 12 months if hired. As required, I agree to a search of the Texas Health and Human Services Commission's OIG List of Excluded Individual/Entities, prior to being hired and monthly thereafter, the HHS - OIG Excluded Individuals/Entities Search Database and SAM Exclusion List. I understand that these checks will determine if I have a criminal conviction or have committed certain conduct that will bar me from employment with this Agency. I understand that I am unemployable if listed as unemployable in the NAR or EMR per TAC 26 TAC Chapter 561, §561.3 and Texas H&SC Chapter 253.

Criminal History Check

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

I acknowledge that if I am found to have been convicted of any offense(s) barring employment, that these offenses may bar my employment. I understand that all information obtained by the Agency regarding any criminal history will remain confidential. I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

Last Name, First, Middle: _____

Maiden/Alias (if applicable): _____

Applicant Signature: _____ Date: _____

For Agency Use Only: Criminal history, Employee Misconduct Registry (EMR), Nurse Aide Registry (NAR), and OIG Exclusion Lists checks completed, as applicable. Attach state-specific background check policy regarding convictions barring employment.

- ❑ Criminal history check completed online https://www.dps.texas.gov/section/crime-records
- ❑ Other convictions identified on criminal history. (Document reason hiring in comments below.)
- ❑ NAR and EMR checked online via Employability Status Check Search at https://emr.dads.state.tx.us/DadsEMRWeb/
- ❑ OIG LEIE checked at https://oig.hhs.texas.gov/exclusions and https://exclusions.oig.hhs.gov/
- ❑ GSA/SAM https://sam.gov/content/home
- ❑ Applicant employable
- ❑ Applicant NOT employable

Comments: _____

Verified by: _____ Date: _____

TB Individual Risk Assessment and Symptom Evaluation

***Healthcare Personnel Name: _____ Date of Assessment: _____**

Reason for completion (check one):

❑Pre-hire Baseline Individual Risk Assessment and Symptom Evaluation

❑Annual Individual Risk Assessment and Symptom Evaluation

TB Risk Assessment

Healthcare Personnel should be considered at increased risk for TB if any of the following statements are marked "Yes". (Note: The TST result is interpreted differently depending on the individual's risk factors.)

	Yes	No
Have you had temporary or permanent residence of greater than one month in a country with a high TB rate? (Any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe)		
Have you been in close contact with someone who has had infectious TB disease since your last TB test?		
Do you have current or planned immunosuppression, including: • Human immunodeficiency virus (HIV) infection • Organ transplant recipient • Treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other) • Treatment with a chronic steroid (equivalent of prednisone greater or equal to 15 mg/day for greater than or equal to one month) or • Treatment with other immunosuppressive medication		

❑ Yes, one or more of the above listed applies **❑ No, none of the above listed apply**

If **Yes** is selected: Healthcare Personnel may have increased risk of TB; If baseline testing is required, results should be interpreted according to risk. Refer to:
https://www.cdc.gov/tb/media/What_You_Need_to_Know_About_the_TB_Skin_Test.pdf

If **No** is selected: Healthcare Personnel has a lower risk for TB infection. If no TB risk factors have been identified and Healthcare Personnel have a TST with a positive result, they will need a confirmatory TST/IGRA test. See Additional Testing at https://academic.oup.com/cid/article/64/2/e1/2629583.

Symptom Evaluation (Required for pre-hire and annually)

Do you currently have any of the following signs or symptoms of TB disease?

❑Cough lasting three weeks or longer?

❑Coughing up blood or sputum

❑Night sweats

❑Unexplained weight loss

❑Fever/chills for no known reason

❑Fatigue

❑Pain in the chest

❑Lack of appetite

❑None of the above apply

TB Individual Risk Assessment and Symptom Evaluation

***Healthcare Personnel Name: _____ Date of Assessment: _____**

Persons with any of the above signs and/or symptoms of TB need further evaluation. This includes a TST/IGRA (Unless there is documentation of previous positive results), a chest x-ray, and full medical exam (sputum collection may be recommended). Healthcare Personnel, including volunteers, may not return to work until after they have been cleared.

❑ I am not experiencing any of the above symptoms.

I understand if I am experiencing any of the above symptoms, follow-up will be required. Additionally, I understand if I have any of the above symptoms at any time in the future, I am to report to management immediately and follow-up will be required at that time.

Signature: _____ Date: _____

For office use only:

❑ Healthcare Personnel has been provided a copy of the CDC's TB Fact sheet from https://www.cdc.gov/tb/communication-resources/tuberculosis-fact-sheet.html

❑ No TB-like symptoms reported or observed.

_____

Name of licensed MD/RN (Print)

_____ _____

Signature of Licensed MD/RN Date/Time

* *Statutory definition of Healthcare Personnel includes volunteers*

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)

General Instructions

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

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

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

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

5. Prefer the most accurate withholding for multiple job situations.

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

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

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

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

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

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

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)					
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)					

Additional Information

☐ 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.
		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		
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				

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.