

Reliant Home Health Agency, Inc.

1041 MacDade Blvd., Folsom, PA 19033
Phone: 610-534-1414 Fax: 610-534-1433
Website: relianthomehealthagencyinc.com

Employment Application

_____ Date

Personal Information

Name Last First Middle Phone

Address City State Zip Code

Previous Address (If you have lived less than 7 years at present address)

Address City State Zip Code

Are you a U.S. citizen? Yes No
Are you over the age of 18? Yes No
Have you ever been convicted of a crime? Yes No If yes, explain number of conviction(s), nature of offense(s) leading to conviction(s), how recently such offense(s) was/were committed, sentence(s) Imposed, and type(s) of rehabilitation.

Have you ever received workmen's compensation? No Yes : Dates received _____
Are you currently receiving workmen's compensation? No Yes

Employment Information

Position Desired: RN LPN CAN HHA Companion Salary Requirement \$ _____
Do you have your own transportation? Yes No Driver's License Number _____
Have you applied here before? Yes No If so when? _____
How were you referred to us? Classified Ad Employee. Please give name _____

Qualification and Experience

Education:

	Did you graduate?	Year
High School _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
College _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Nursing School _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Technical School _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Do you have current CPR certification? Yes No Expiration date _____
Do you have other training, experience, skills, qualifications which make you especially suited for employment with this agency? _____
Language(s) spoken in addition to English _____
Are you trained to speak in American Sign Language(ASL) Yes No

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Availability

Circle days and indicate time(s) you are available to work: Sunday _____ Monday _____
Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____

Employment History

Current Employer _____ Position _____
Address _____
Salary _____ Date of employment _____
Reason for leaving _____ May we contact supervisor? Yes No
Supervisor's Name _____ Phone _____

Previous Employer: _____ Position _____
Address _____
Salary _____ Date of employment _____
Reason for leaving _____ May we contact supervisor? Yes No
Supervisor's Name _____ Phone _____

Previous Employer: _____ Position _____
Address _____
Salary _____ Date of employment _____
Reason for leaving _____ May we contact supervisor? Yes No
Supervisor's Name _____ Phone _____

Personal References

Please list the names, addresses and phone number of three persons not related to you, whom you have known for at least a year:

Name _____ Years Acquainted _____
Address _____ Phone _____

Name _____ Years Acquainted _____
Address _____ Phone _____
Business _____

Name _____ Years Acquainted _____
Address _____ Phone _____
Business _____

Emergency Contact

Name _____ Phone _____ Relationship to you _____

I verify that my answers are true and complete to the best of my knowledge. In the even I am employed, I understand that false or misleading information given in my application or interview(s) may result in discharge.

Signature

Date

Form W-4 (2018)

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

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

Exemption from withholding. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at www.irs.gov/W4App to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at www.irs.gov/W4App to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at www.irs.gov/W4App to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. Head of household please note:

Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

----- Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074 2018
▶ Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.				
1 Your first name and middle initial		Last name		2 Your social security number
Home address (number and street or rural route)			3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code			4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. <input type="checkbox"/>	
5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)			5
6	Additional amount, if any, you want withheld from each paycheck			6 \$
7	I claim exemption from withholding for 2018, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶			
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.				
Employee's signature (This form is not valid unless you sign it.) ▶				Date ▶
8 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)			9 First date of employment	10 Employer identification number (EIN)

your wages and other income, including income earned by a spouse, during the year.

Line G. Other credits. You might be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as the earned income tax credit and tax credits for education and child care expenses. If you do so, your paycheck will be larger but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at www.irs.gov/W4App. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more

than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn \$60,000 per year and your spouse earns \$20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at www.irs.gov/W4App to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are

required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to www.acf.hhs.gov/programs/css/employers.

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Personal Allowances Worksheet (Keep for your records.)

- A** Enter "1" for yourself **A** _____
- B** Enter "1" if you will file as married filing jointly **B** _____
- C** Enter "1" if you will file as head of household **C** _____
- D** Enter "1" if: {
 - You're single, or married filing separately, and have only one job; or
 - You're married filing jointly, have only one job, and your spouse doesn't work; or
 - Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.} **D** _____
- E Child tax credit.** See Pub. 972, Child Tax Credit, for more information.
 - If your total income will be less than \$69,801 (\$101,401 if married filing jointly), enter "4" for each eligible child.
 - If your total income will be from \$69,801 to \$175,550 (\$101,401 to \$339,000 if married filing jointly), enter "2" for each eligible child.
 - If your total income will be from \$175,551 to \$200,000 (\$339,001 to \$400,000 if married filing jointly), enter "1" for each eligible child.
 - If your total income will be higher than \$200,000 (\$400,000 if married filing jointly), enter "-0-" **E** _____
- F Credit for other dependents.**
 - If your total income will be less than \$69,801 (\$101,401 if married filing jointly), enter "1" for each eligible dependent.
 - If your total income will be from \$69,801 to \$175,550 (\$101,401 to \$339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents).
 - If your total income will be higher than \$175,550 (\$339,000 if married filing jointly), enter "-0-" **F** _____
- G Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here . . . **G** _____
- H** Add lines A through G and enter the total here **H** _____

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed \$52,000 (\$24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

- 1** Enter an estimate of your 2018 itemized deductions. These 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. See Pub. 505 for details **1** \$ _____
- 2** Enter: {
 - \$24,000 if you're married filing jointly or qualifying widow(er)
 - \$18,000 if you're head of household
 - \$12,000 if you're single or married filing separately} **2** \$ _____
- 3 Subtract** line 2 from line 1. If zero or less, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items) **4** \$ _____
- 5 Add** lines 3 and 4 and enter the total **5** \$ _____
- 6** Enter an estimate of your 2018 nonwage income (such as dividends or interest) **6** \$ _____
- 7 Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses . . . **7** \$ _____
- 8 Divide** the amount on line 7 by \$4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction **8** _____
- 9** Enter the number from the **Personal Allowances Worksheet**, line H above **9** _____
- 10 Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 **10** _____

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

- 1** Enter the number from the **Personal Allowances Worksheet**, line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) **1** _____
 - 2** Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you're married filing jointly and wages from the highest paying job are \$75,000 or less and the combined wages for you and your spouse are \$107,000 or less, don't enter more than "3" **2** _____
 - 3** If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet **3** _____
- Note:** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.
- 4** Enter the number from line 2 of this worksheet **4** _____
 - 5** Enter the number from line 1 of this worksheet **5** _____
 - 6** **Subtract** line 5 from line 4 **6** _____
 - 7** Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here **7** \$ _____
 - 8** **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed **8** \$ _____
 - 9** **Divide** line 8 by the number of pay periods remaining in 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck **9** \$ _____

Table 1				Table 2			
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$5,000	0	\$0 - \$7,000	0	\$0 - \$24,375	\$420	\$0 - \$7,000	\$420
5,001 - 9,500	1	7,001 - 12,500	1	24,376 - 82,725	500	7,001 - 36,175	500
9,501 - 19,000	2	12,501 - 24,500	2	82,726 - 170,325	910	36,176 - 79,975	910
19,001 - 26,500	3	24,501 - 31,500	3	170,326 - 320,325	1,000	79,976 - 154,975	1,000
26,501 - 37,000	4	31,501 - 39,000	4	320,326 - 405,325	1,330	154,976 - 197,475	1,330
37,001 - 43,500	5	39,001 - 55,000	5	405,326 - 605,325	1,450	197,476 - 497,475	1,450
43,501 - 55,000	6	55,001 - 70,000	6	605,326 and over	1,540	497,476 and over	1,540
55,001 - 60,000	7	70,001 - 85,000	7				
60,001 - 70,000	8	85,001 - 90,000	8				
70,001 - 75,000	9	90,001 - 100,000	9				
75,001 - 85,000	10	100,001 - 105,000	10				
85,001 - 95,000	11	105,001 - 115,000	11				
95,001 - 130,000	12	115,001 - 120,000	12				
130,001 - 150,000	13	120,001 - 130,000	13				
150,001 - 160,000	14	130,001 - 145,000	14				
160,001 - 170,000	15	145,001 - 155,000	15				
170,001 - 180,000	16	155,001 - 185,000	16				
180,001 - 190,000	17	185,001 and over	17				
190,001 - 200,000	18						
200,001 and over	19						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and

U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You aren't required to provide the information requested on a form that's subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be

retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

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

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



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number □□□□ - □□ - □□□□		Employee's E-mail Address		Employee's Telephone Number	

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

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

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> QR Code - Section 1 Do Not Write In This Space </div>	

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

Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code





Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

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

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

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

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 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 	OR	<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Reliant Home Health Agency, Inc.

**1041 MacDade Blvd., Folsom, PA 19033
Phone: 610-534-1414 Fax: 610-534-1433
Website: relianthomehealthagencyinc.com**

Hepatitis B Declination Form

I understand that due to the occupational risk of exposure to blood or other potentially infectious material, I may be at risk of acquiring hepatitis B virus (HBV) infection which is a serious disease.

I understand that if I decline to obtain this vaccination series, I will continue to be at risk of acquiring hepatitis B.

If I decide I want to receive the hepatitis B vaccination series, I will be provided resources where this vaccine can be obtained.

I am declining to obtain the vaccine

Date

Reliant Representative

Date

Reference Check Form

I voluntarily give Reliant Home Health Agency, Inc. the right to investigate my past and/or present employment, and release Reliant Home Health from all liability or responsibility by all persons, companies, or organizations supplying information.

Applicant signature _____ Date _____

To Employer: _____

Applicant Name: _____

Social Security Number: _____ - _____ - _____

Has applied for employment with our company. Please assist us in making a decision regarding employment that will best benefit this applicant and our organization by providing the requested information below.

Sincerely, _____ Date _____

RHHA Representative

Date

Employment Dates: _____

Eligible for rehire? Yes _____ No _____

Position Held: _____

Final Salary \$ _____

Reason for termination/separation _____

Please rate this individual on the basis of his/her employment with you:

Quality of work Exceptional Satisfactory Unsatisfactory

Quantity of work Exceptional Satisfactory Unsatisfactory

Ability Exceptional Satisfactory Unsatisfactory

Attendance Exceptional Satisfactory Unsatisfactory

Reference information proved by: _____ Job Title _____

Verified by: _____ Phone _____ Mail _____

Verified by: _____ Job Title _____

Reliant Home Health Agency, Inc.

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Policy: Confidentiality of Client Information

By accepting employment with Reliant Home Health Inc., I agree to carefully refrain from discussing any client's condition or personal affairs with anyone outside the agency, unless expressly authorized to do so.

I will not share any medical information with other clients or visitor without clear instruction provided to the agency. I acknowledge that all information see or heard regarding clients, directly or indirectly, is completely confidential and is not to be discussed, even with my family or coworkers.

I will not share any information about clients or the agency with the media. This is essential for protection of both client and the Agency.

My job as a Reliant Home Health Inc., requires that I govern myself by high ethical standards. Failure to recognize the importance confidentiality is not only a breach of professional ethics, but can also involve an employee in legal proceedings.

I have read and understood the above statements and agree to abide by this policy. I understand that breach of policy may result in disciplinary action and possible dismissal from employment.

Employee Signature	Date
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Witness Signature	Date
-------------------	------

Reliant Home Health Agency, Inc.

**1041 MacDade Blvd., Folsom, PA 19033
Phone: 610-534-1414 Fax: 610-534-1433
Website: relianthomehealthagencyinc.com**

Reliant Home Health Agency only provides work for employment if, and only if, clients are available to be serviced.

1. In the event no clients are available to be services, Reliant Home Health is **NOT** responsible in any way to provide work hours for the employee and/or contractors.
2. It is the policy of Reliant Home Health Agency employee and/or contractors
 - a. **NOT** to provide client transportation and,
 - b. **NOT** to transport any client in private vehicle.

I have read and understand the above standards.

Employee or Contractor Signature

Date

Reliant Representative

Date

Employee Safe Working Practices Agreement

Any condition of employment, I _____ do hereby agree to comply with the following safe working practices:

1. I agree to report any work-related accident or injury to my supervisor as soon as it occurs, and no later than the end of my work shift.
2. If I need treatment for a work-related injury, I agree to notify the agency of the need for treatment as soon as possible.
3. If my job involves the handling of patients, I agree to enlist assistance or use a mechanical lifting device for all patients whom I cannot safely handle by myself.
4. I agree to utilize available personal protective equipment to help assure my safety from physical injury or infection.
5. I agree to maintain a valid driver's license and automobile insurance, and to notify the agency immediately if any time they should become invalid.
6. I affirm that I am physically and mentally able to perform the required duties for the job of nurse's aide. If at any time there is a change making me unable to do so, then I agree to notify the agency immediately.

I have read and agree to the above established agency safety procedures. I understand that a failure on my part to follow the above procedures could result in disciplinary action as outlined with the Reliant Home Health Agency disciplinary action policy.

Employee or Contractor Signature

Date

Reliant Representative

Date

Home Health Aide Job Requirements and Responsibilities

Qualification:

1. Applicants must show proof of having completed a training and competency evaluation program that meets the minimum standard established by this agency, and is competent to furnish home health services.
2. The applicant will be subject to a criminal history check. If there is no negative report, the position can be confirmed.
3. All required documentation must be submitted within ninety (90) days of hire or the applicant will be terminated from their position until all documentation is received.

Duties:

The role of a Home Health Aide will include, but not be limited to:

1. Assisting and documenting patient activities and care performed as outlined in the aide care plan at each visit.
2. Assisting with daily patient care such as bathing, shampoo, oral hygiene, skin care and dressing.
3. Obtaining and recording vital signs when ordered.
4. Meal preparation when ordered.
5. Supervision of medications when ordered.
6. Reporting and documenting changes in the patient's condition in a timely manner.
7. Maintaining patient confidentiality at all times.

Duties Not To Be Performed:

1. Sterile dressing changes.
2. Turning off or on tube feedings.
3. Irrigation of tubes including, Foleys, feeding tubes or ostomies.
4. Administer tube feedings.
5. Administer enemas or douches.
6. Perform tracheostomy care.
7. Make medical judgments.
8. Any other duties not within the scope of practice of a home health aide.

I have read and understand the contents of this document.

Signature of Applicant

Date

Agency Representative

Date

Standards and Policies for Home Health Aide

Requirements for employment:

1. Reliant Home Health prefers applicants that have completed a training and competency evaluation program that meets the minimum standard established by the state of Pennsylvania, and can present documentation indicating that they are in good standing with the Pennsylvania licensing board. Reliant Home Health does reserve the right to not accept anyone with experience that is felt to be inadequate to service non-skilled clients, and or provided needed training.
2. Must clear a criminal history check with no negative reports before being hired.
3. Must present documentation verifying your eligibility for employment as established by the Department of Homeland Security. (Form 19)
4. Must present documentation of a physical examination, and documentation of a negative tuberculosis (TB) test within the last twelve (12) months.
5. Must present current documentation of successful completion of CPR certification for adults.
6. Must past or present current documentation of Pennsylvania Child Abuse History Clearance.
7. If all of the above documentation is not completed within 30 days of employment, you will be immediately dismissed from employment at Reliant Home Health, until such requirements are completed in full.
8. In compliance with state guidelines, any employee who has not been a resident of the Commonwealth for less than 2 years will be hired for a provisional period not to exceed 90 days.
9. Pay checks will be distributed every other Friday between 12 noon and 4pm. You will not be able to pick up another co-workers pay check or vice versa without a signed note authorizing you to do so.
10. Requests for time off must be submitted in writing at least two (2) weeks in advance of request to the office secretary.
11. As an employee of Reliant Home Health, you will be required to maintain a good standing with the state and federal licensing boards. Prior to your hire, your license and social security status will be checked and monthly thereafter. If at any time a negative notation should appear on any employee the individual will be suspended immediately. For the individual to resume work, a letter of clearance from the board must be provided to the agency.

Service Guidelines

1. All employees are expected to dress in a manner appropriate to the health care environment.
2. You are expected to report for your agreed upon scheduled work shift ON TIME.
3. You will be expected to call into the office upon arriving and departing from the client's home.
4. Consistency in imperative when serving other. If you should call off duty three (3) times, you will be removed from servicing the client, and the client reassigned.
5. In the event no clients are available to be served, Reliant Home Health is NOT responsible in any way to provide work hours for the employee.
6. In case of a personal emergency:
 - a. You must call Reliant Home Health office at least 8 hours before the start of your shift and inform us that you will not be available for your scheduled shift.
 - b. Reliant Home Health will be responsible for notifying your client that you will not be serving them for that shift.

7. When in the client's home, you are:
 - a. Expected to honor the confidentiality of any client information which is obtained.
 - b. Not allowed to smoke in a client's house or on their property.
 - c. Not to dispense or administer any medications under any circumstances.
 - d. Not to ask for, or accept any money or property from the client or family member.
 - e. Not to be involved with the client's financial affairs (i.e. check writing, bank deposit/withdrawals).
 - f. Make personal phone calls or text on your personal phone or the client's phone while on assignment.
 - g. Not to transport a client for any reason. If you should choose to do so, Reliant Home Health will not be held responsible for your actions or injuries resulting from such action.
 - h. In case of an emergency in the client's home, you must call Reliant Home Health office as soon as possible and inform us of the nature of the emergency.
8. As an employee of the Agency, you are not authorized to accept any direct employment that may be offered to you by a client or family member. If you are requested to do so, please have the client/family member contact the Agency.
9. During your employment at this Agency, all proprietary material (i.e. forms, medical records etc.) will be used only in connection with employment and will not be disclosed to anyone without authorization from the agency.
10. As an employee of Reliant Home Health, you will be required to maintain a good standing with the state and federal boards. Prior to your hire, your license and social security status will be checked and monthly thereafter. If at any time a negative notation should appear on any employee, the individual will be suspended immediately. For the individual to resume work, a letter of clearance from the board must be provided to the agency.

Documentation

1. All required documentation, including time sheets, must be filled out properly and returned to the office on Monday by the close of the day.
2. Your time sheet must be signed by the client or a family member or designated person for each shift. You will not be paid for the shift if there is no signature.
3. The Center for Medicare and Medicaid (CMS) monitors the services being rendered in according to state and national guidelines, and that they are billed according to the documented services. CMS verifies and collects information prior to making onsite visits to client's home, as well as gather information from the client and home health aide during their home visit. If you and/or the client should misrepresent any documented information, you could be prosecuted for intentional fraud and the client lose benefits.

I have read and understand all of the above standards and policies.

Employee Signature _____ Date_____

PENNSYLVAN
IA CHILD ABUSE HISTORY CLEARANCE

COMPLETE SECTION 1 ONLY. Print clearly in ink. Enclose \$10.00 money order ONLY.
 Payable to DEPARTMENT OF PUBLIC WELFARE. DO NOT send cash or personal check.

SEND TO CHILDLINE AND ABUSE REGISTRY, DEPARTMENT OF PUBLIC WELFARE, P.O. BOX
 8170 HARRISBURG, PA 17105-8170

APPLICATIONS THAT ARE INCOMPLETE, ILLEGIBLE OR RECEIVED WITHOUT FEE WILL BE
 RETURNED UNPROCESSED. IF YOU HAVE QUESTION CALL 717-783-6211, OR (TOLL FREE)
 1-877-371-5422

CHILDLINE USE ONLY
DATE RECEIVED BY CHILDLINE

SECTION 1 APPLICANT IDENTIFICATION

IN THIS SPACE PRINT APPLICAN'T FULL NAME AND ADDRESS (DO NOT USE INITIALS)

NAME	SOCIAL SECURITY NUMBER		
STREET	AGE	DATE OF BIRTH	DAYTIME PHONE NO.
CITY, STATE	COUNTRY YOU LIVE IN		
ZIP CODE	SEX <input type="checkbox"/> M <input type="checkbox"/> F		

Disclosure of your Social Security number is voluntary. It is sought under 23 Pa.C.S. 6336(a)(1) relating to information in statewide central register), 6344 (relating to information relating to prospective child care personnel), 6344. 1 (relating to information relating to family day-care home residents), and 6344. 2 (relating to information relating to other persons having contact with children). The department will use your Social Security number to search the statewide central register to determine whether you are listed as the perpetrator in an indicated or founded report of child abuse.

PURPOSE OF CLEARANCE (Check One block ONLY)
<input type="checkbox"/> Child Care Services Employee
<input type="checkbox"/> Foster Care <input type="checkbox"/> Adoption <input type="checkbox"/> School Employee
<input type="checkbox"/> Employment with a significant likelihood of regular contact with children
<input type="checkbox"/> Volunteers – A copy of your PROCESSED Request for Criminal Record” (From SP4-164) must be attached. Out-of-state residents must also attach a copy of their PROCESSED FBI clearance (Form FD-258).
<input type="checkbox"/> DPW Employment & Training Program Participant (signature required below)
_____ SIGNATURE OF OIM/CAO REPRESENTATIVE
_____ OIM/CAO PHONE NUMBER

PREVIOUS NAMES USED SINCE 1975 (Include Maiden Name, Nicknames, Aliases)
1. (Last, First, Middle)
2. (Last, First, Middle)
3. (Last, First, Middle)
4. (Last, First, Middle)
5. (Last, First, Middle)

PREVIOUS ADDRESSES SINCE 1975 (Attach additional pages if necessary)
1.
2.
3.
4.

HOUSEHOLD MEMBER (List everyone who lived with you at any time since 1975 to the present)			
NAME (Last, First, Middle) Do not use initials.	RELATIONSHIP	PRESENT AGE	SEX
1.			
2.			
3.			
4.			
5.			
6.			

I certify that the above information is accurate and complete to the best of my knowledge and belief and submitted as true and correct under penalty of law (Section 4904 of the Pennsylvania Crimes Code).

Applicants are required to show the administrator the original document. Administrators are required to keep a copy of this child abuse history record on file. Any person altering the contents of this document may be subject to civil criminal or administrative action.	_____ APPLICANT'S SIGNATURE	_____ DATE
--	--------------------------------	---------------

DO NOT WRITE IN THIS SECTION – CHILDLINE USE ONLY

SECTION II		RESULTS OF HISTORY CHECK	
<input type="checkbox"/> APPLICANT IS NOT LISTED IN A REPORT OF CHILD ABUSE OR A REPORT FOR SCHOOL EMPLOYEE.		<input type="checkbox"/> APPLICANT IS LISTED IN A REPORT OF CHILD ABUSE OR A REPORT FOR SCHOOL EMPLOYEE (SEE BELOW).	
STATUS OF REPORT	DATE OF INCIDENT	STATUS OF REPORT	DATE OF INCIDENT
1.		3.	
2.		4.	
_____		_____	
VERIFIER	DATE	VERIFIER'S SUPERVISOR	DATE

SECTION III		VOLUNTARY CERTIFICATION FOR CHILD CARE SERVICES	
<p>_____ Has requested a certification which includes a clearance of his/her name against the child abuse, school employee, and criminal history reports.</p> <p>The results of the child abuse and school employee report clearances are listed in Section II on the reverse side. The results of the criminal history reports are listed below. Out-of-state residents must have criminal history clearance from both the Pennsylvania State Police and the FBI. The voluntary certification may be obtained every two years.</p> <p>It is the responsibility of parents and guardians to review this information to determine the suitability of the applicant as a substitute caregiver.</p>			
PENNSYLVANIA CHILD ABUSE HISTORY CLEARANCE			
<input type="checkbox"/> Applicant is named as the perpetrator of a founded child abuse or school employee report which occurred in the last five years. <input type="checkbox"/> Applicant is named as the perpetrator of a founded child abuse or school employee report which occurred over five years ago. <input type="checkbox"/> Applicant is named as the perpetrator of an indicated child abuse or school employee report. <input type="checkbox"/> Applicant is not named as the perpetrator of any child abuse or school employee report contained in the Statewide Central Register.			
PRNNSYLVANIA STATE POLICE CLEARANCE			
<input type="checkbox"/> Record exists and contains convictions which prohiit hire in a child care position. Report attached. <input type="checkbox"/> Record exists, but convictions do not prohibit hire in a child care position. Report attached. <input type="checkbox"/> Record exists, but no convictions are shown. This does not prohibit hire in a child care position. Report attached. <input type="checkbox"/> No record exists. Report attached.			
FBI CLEARANCE			
<input type="checkbox"/> Record exists and contains convictions which prohibit hire in a child care position. Report attached. <input type="checkbox"/> Record exists, but convictions do not prohibit hire in a child care position. Report attached. <input type="checkbox"/> Record exists, but no convictions are shown. This may not prohibit hire in a child care position. Report attached. <input type="checkbox"/> No record exists, Report Attached. <input type="checkbox"/> No FBI clearance required.			
_____		_____	
VERIFIER	DATE	VERIFIER'S SUPERVISOR	DATE