

DOCUMENTS NEEDED BEFORE TO BE HIRE:

RN – LPN

- ◆ Driver's License
- ◆ Social Security (If not a citizen the, Passport, Resident Card, and/or Voters Card)
- ◆ CPR Card (Copy of Front and Back of the Card and it cannot be an online course)
- ◆ Proof of Auto Insurance and Registration (Policy for 1 year or 6 months)
- ◆ Florida RN / LPN License
- ◆ Proof of Liability Insurance
- ◆ Proof of FLU Vaccine (Or decline thru statement)
- ◆ Physical Exam
- ◆ PPD / TB Test
- ◆ REFERENCES (2)
- ◆ IN SERVICES:
 - HIV/AIDS (4hrs for the initial one)
 - HIPAA
 - OSHA
 - ALZHEIMER'S
 - INFECTION CONTROL
 - MEDICAL ERRORS
 - DOMESTIC VIOLENCE
 - LAWS and RULES
 - RECOGNIZING IMPAIRMENT IN THE WORKPLACE
 - HUMAN TRAFFICKING
 - ABUSE, NEGLECT and EXPLOITATION TRAINING
 - FRAUD, WASTE and ABUSE

*** Every IN SERVICE has to be updated every 2 YEARS w/ LICENSE Renewal ***

ADVANTIS HOME CARE INC
7260 Sw 39th Terr Unit A Miami FL 33189

APPLICANT INFORMATION					
Last Name		First		M.I.	Date
Street Address				Date of Birth	
City		State		ZIP	
Phone		E-mail Address			
Date Available		Social Security No.		Desired Salary	
Position Applied for			Driver License		
Are you a citizen of the United States?	YES	NO	If no, are you authorized to work in the U.S.?	YES	NO
Have you ever worked for this company?	YES	NO	If so, when?		
Have you ever been convicted of a felony?	YES	NO	If yes, explain		

EDUCATION					
High School		Address			
From	To	Did you graduate?	YES	NO	Degree
College		Address			
From	To	Did you graduate?	YES	NO	Degree
Other		Address			
From	To	Did you graduate?	YES	NO	Degree

REFERENCES	
Please list three professional references.	
Full Name	Relationship
Company	Phone ()
Address	
Full Name	Relationship
Company	Phone ()
Address	
Full Name	Relationship
Company	Phone ()
Address	

PREVIOUS EMPLOYMENT			
Company		Phone ()	
Address		Supervisor	
Job Title	Starting Salary \$	Ending Salary \$	
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES NO			
Company		Phone ()	
Address		Supervisor	
Job Title	Starting Salary \$	Ending Salary \$	
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES NO			
Company		Phone ()	
Address		Supervisor	
Job Title	Starting Salary \$	Ending Salary \$	
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES NO			

MILITARY SERVICE	
Branch	From To
Rank at Discharge	Type of Discharge
If other than honorable, explain	

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision. I understand that this application is not intended to be contract of employment. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature _____

Date _____

FOR INTERNAL USE ONLY:

Interviewed By: _____

Approved By: _____

Date: _____

ADVANTIS HOME CARE INC

REFERENCE INFORMATION REQUEST

(Applicant to complete to double line)

Reference Name: _____

Agency name: _____

Telephone: _____

I have applied to the Agency for a position as a/an _____.
I authorize you to respond to the questions below so they may act on my application. I release you from all liability in supplying this information regarding my employment with you.

Applicant's Signature _____

Print Applicant's Name _____

I worked for you from _____ to _____

as a/an _____

To be completed by former employer: Would you rehire? Yes _____ No _____

Is the above information correct? Yes _____ No _____

If no please explain: _____

	EXCELLENT	VERY GOOD	GOOD	POOR
Job Skill				
Job Knowledge				
Initiative				
Attendance				
Ability to Work with Others				
Judgement				
Honesty				
Ability to accept Direction				
Grooming and Appearance				
Time Management				

Comments:

Title: _____

Signature: _____

ADVANTIS HOME CARE INC

REFERENCE INFORMATION REQUEST

(Applicant to complete to double line)

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	EXCELLENT	VERY GOOD	GOOD	POOR
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Attendance				
Ability to Work with Others				
Judgement				
Honesty				
Ability to accept Direction				
Grooming and Appearance				
Time Management				

Comments:

Title: _____

Signature: _____



Prepared by the Florida Health Care Association with the assistance of the Alzheimer Resource Center of Tallahassee, Florida to meet the statutory requirement of 400.4785(1) (a) F.S.

ALZHEIMER'S DISEASE (AD) AND RELATED DEMENTIAS

History

Alzheimer's disease (AD) was first discovered in 1906 by a German doctor named Alois Alzheimer. It is a disorder of the brain, causing damage to brain tissue over a period of time. The disease can linger from 2 to 25 years before death results. AD is a progressive, debilitating and eventually fatal neurological illness affecting an estimated 4-5 million Americans. It is the most common form of dementing illness.

Alzheimer's disease is characterized clinically by early memory impairment followed by language and perceptual problems. This disease can affect anyone - it has no economic, social, racial or national barriers.

Causes

There is no one cause for Alzheimer's disease. AD may be sporadic or passed through the genetic make-up. The disease causes gradual death of brain tissue due to biochemical problems inside individual brain cells. The symptoms are progressive, but there is great variation in the rate of change from one person to another. Although in the early stages of Alzheimer's the victim may appear completely healthy, the damage is slowly destroying the brain cells. The hidden process damages the brain in several ways:

- Patches of brain cells degenerate (neuritic plaques)
- Nerve endings that transmit messages become tangled (neurofibrillary tangles)
- There is a reduction in acetylcholine, an important brain chemical (neurotransmitter)
- Spaces in the brain (ventricles become larger and filled with granular fluid)
- The size and shape of the brain alters - the cortex appears to shrink and decay

Understandably, as the brain continues to degenerate, there is a comparable loss in mental functioning. Since the brain controls all of our bodily functions, an Alzheimer victim in the later stages will have difficulty walking, talking, swallowing and controlling bladder and bowel functions. They become quite frail and prone to infections such as pneumonia.

Dementia vs. Normal Aging

As a person grows older, he/she worries that forgetting the phone number of a best friend must mean he/she is becoming demented or getting Alzheimer's disease. Forgetfulness due to aging or increased stress is *not* normal aging and is *not* dementia.

"Dementia" is an encompassing term for numerous forms of memory loss. There are many types of dementia such as Alzheimer's disease, Multi-Infarct dementia or Parkinson's disease. When a person has dementia, he/she will lose the ability to think, reason and remember and will inevitably need assistance with everyday activities such as dressing and bathing. Changes in personality, mood are also symptoms of dementia. Many dementias are treatable and reversible. Alzheimer's disease is the most common form of untreatable, irreversible dementia.

Alzheimer's Disease - Stages of Progression

Alzheimer's Disease can be characterized as having early, middle, and late stages through which the patient gradually progresses, but not at a predictable rate. The range of the course of the disease is 2-25 years. NOTE: Stages very often overlap. Everyone progresses through these stages differently.

First Stage: This is a very subtle stage usually not identified by either the impaired person or the family as the beginning signs of the disease. Subtle changes in memory and language along with some confusion occur at this time. The family usually denies or excuses the performance deficiencies at this stage.

- Forgetfulness/memory loss
- Impaired judgment
- Trouble with routines
- Lessening of initiative
- Disorientation of time and places
- Depression
- Fearfulness
- Personality change
- Apraxia (forgetting how to use tools and equipment)
- Anomia (forgetting the right word or name of a person)

Second Stage: As Stage 1 moves onto Stage 2, there is usually a particular significant event which forces the family (and impaired person) to consider that something is really wrong. At this time, they usually go to a doctor to diagnose the problem.

- Poor short-term memory
- Wandering (searching for home)
- Language difficulties
- Increased disorientation
- Social withdrawal
- More spontaneity, fewer inhibitions
- Agitation and restlessness, fidgeting, pacing
- Developing inability to attach meaning to sensory perceptions: (taste, touch, smell, sight, hearing)
- Inability to think abstractly
- Severe sleep disturbances and/or sleepiness
- Convulsive seizures may develop
- Repetitive actions and speech
- Hallucinations
- Delusions

Third (Final Stage): This stage is the terminal stage and may last for months or years. The individual will eventually need total personal care. They may no longer be able to speak or recognize their closest relatives.

- Little or no memory
- Inability to recognize themselves in a mirror
- No recognition of family or friends
- Great difficulty communicating
- Difficulty with coordinated movements
- Becoming emaciated in spite of adequate diet
- Complete loss of control of all body functions
- Increased frailty
- Complete dependence

COMMON PROBLEMS WITH DEMENTIA

Delusions

Suspiciousness: accusing others of stealing their belongings

People are "out to get them"

Fear that caregiver is going to abandon (results in AD person never leaving caregiver's side)

Current living space is not "home"

Hallucinations

Seeing or hearing people who are not present

Repetitive actions or questions

They forget they asked the question

Repetitive action such as wringing a towel

Wandering

Pacing

Sundowning: trying to get "home"

Generally feeling uncomfortable or restless

Increased agitation at night

Losing thing/Hiding things

Simply do not remember where items are

Might hide things so that people don't "steal" them

Inappropriate sexual behavior

Person with AD loses social graces and is only doing what feels good

Agnosia: inability to recognize common people or objects

A wife of forty years will become a stranger to the person with AD, he might even think she is the hired help

Might not recognize a spatula or the purpose of the spatula and/or cannot verbalize the name or purpose of the object

Apraxia: loss of ability to perform purposeful motor movements

Cannot tie a shoe or manipulate buttons on a shirt

Catastrophic reactions

(Causes) AD person often becomes excessively upset and can experience rapidly changing moods. The person becomes overwhelmed due to factors such as too much noise, too many people around, unfamiliar environment, routine change, being asked to many questions, being approached from behind.

(Reactions) AD person may become angry, agitated, weepy, stubborn or physically violent. It is best to attempt to avoid catastrophic reactions rather than dwell on how to handle them.

HANDLING DISTURBING BEHAVIORS

One of the most difficult challenges for caregivers is how to handle some of the disturbing behaviors that Alzheimer's can cause. Symptoms such as delusion, hallucinations, angry outbursts, suspiciousness, failure to recognize familiar people and places are often the most upsetting behaviors for families. The following points may help in responding to disturbing symptoms.

First, try to understand if there is a precipitating factor causing the behavior. Were there household changes, too much noise or activity, was the daily routine upset? Time of day can also affect behavior (Sundowning). Being aware of these factors can help to better plan activities or anticipate problems.

1. Keep tasks, directions and routine simple without being condescending
2. Always give the person plenty of time to respond
3. Attempt to remain calm and remind yourself that the behavior is due to the disease
4. Avoid arguing
5. Write down the answers to frequently asked questions, then remind them to look at the message
6. Reduce environmental noise: television, radio, too many people talking
7. Use distraction when unacceptable behavior starts: bring them into a different room, start talking about childhood or another favorite topic, show them magazines, ask them to help you do something like dusting or sweeping
8. Do not overreact or scold for problem behavior: redirect or distract
9. Be reassuring with touch, eye contact and tone of voice
10. Find the familiar: old pipe, favorite chair, family pictures
11. Avoid denying hallucinations: try non-committal comments like, "You spoke with your mother, I miss my mother too"
12. Be sure to inform physician of hallucinations, no matter how tame
13. Restless behavior or pacing is usually unavoidable, however you can make the environment safe by installing locks that are above reach, remove unnecessary obstacles, make sure the person is wearing some kind of identification

ACKNOWLEDGMENT

I acknowledge that I have received a copy of the Alzheimer's disease and related Dementias handout, and I do commit to read this information.

I am aware that if, at any time, I have questions regarding this handout I should direct them to my Director of Nursing or the Administrator.

Employee's Printed Name

Position

Employee's Signature

Date



ATTESTATION OF COMPLIANCE with Background Screening Requirements

Authority: This form shall be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer, **AND**
- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes**, which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:

Health Care Provider/ Employer Name:

Address of Health Care Provider:

You must attest to meeting the requirements for employment and you may not have been arrested for and awaiting final disposition of, have been found guilty of, regardless of adjudication, or have entered a plea of nolo contendere (no contest) or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under *any* of the following provisions of state law or similar law of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

- (a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
- (b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
- (c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
- (d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- (e) Section 782.04, relating to murder.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

- (m) Section 787.02, relating to false imprisonment.
- (n) Section 787.025, relating to luring or enticing a child.
- (o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.
- (p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.
- (q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.
- (r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.
- (s) Section 794.011, relating to sexual battery.
- (t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.
- (u) Section 794.05, relating to unlawful sexual activity with certain minors.
- (v) Chapter 796, relating to prostitution.
- (w) Section 798.02, relating to lewd and lascivious behavior.
- (x) Chapter 800, relating to lewdness and indecent exposure.
- (y) Section 806.01, relating to arson.
- (z) Section 810.02, relating to burglary.
- (aa) Section 810.14, relating to voyeurism, if the offense is a felony.
- (bb) Section 810.145, relating to video voyeurism, if the offense is a felony.
- (cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.
- (dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.
- (ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.
- (ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.
- (gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.
- (hh) Section 826.04, relating to incest.
- (ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.
- (jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.
- (kk) Former s. 827.05, relating to negligent treatment of children.
- (ll) Section 827.071, relating to sexual performance by a child.
- (mm) Section 843.01, relating to resisting arrest with violence.
- (nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.
- (oo) Section 843.12, relating to aiding in an escape.
- (pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.
- (qq) Chapter 847, relating to obscene literature.
- (rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.
- (ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.
- (tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.
- (uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.
- (vv) Section 944.40, relating to escape.
- (ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.
- (xx) Section 944.47, relating to introduction of contraband into a correctional facility.
- (yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.
- (zz) Section 985.711, relating to contraband introduced into detention facilities.
- (3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

- (a) Any authorizing statutes, if the offense was a felony.
- (b) This chapter, if the offense was a felony.
- (c) Section 409.920, relating to Medicaid provider fraud.
- (d) Section 409.9201, relating to Medicaid fraud.
- (e) Section 741.28, relating to domestic violence.
- (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- (g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
- (h) Section 817.234, relating to false and fraudulent insurance claims.
- (i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
- (j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.
- (k) Section 817.505, relating to patient brokering.
- (l) Section 817.568, relating to criminal use of personal identification information.

- (m) Section 817.60, relating to obtaining a credit card through fraudulent means.
- (n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
- (o) Section 831.01, relating to forgery.
- (p) Section 831.02, relating to uttering forged instruments.
- (q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
- (r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.
- (s) Section 831.30, relating to fraud in obtaining medicinal drugs.
- (t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.
- (u) Section 895.03, relating to racketeering and collection of unlawful debts.
- (v) Section 896.101, relating to the Florida Money Laundering Act.

I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).

Date of Decision: _____

I have been granted an Exemption from Disqualification through the Florida Department of Health.

Date of Decision: _____

****A copy of the Exemption from Disqualification decision letter must be attached****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening: _____
Screening conducted by: _____ Date of Prior Screening: _____

- Agency for Healthcare Administration
- Department of Health
- Agency for Persons with Disabilities

- Department of Elder Affairs
- Department of Financial Services
- Department of Children and Families

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

Employee/Contractor Signature

Title

Date

ADVANTIS HOME CARE INC

EMERGENCY NOTIFICATION

EMPLOYEE'S NAME: _____ DATE: _____

In case of emergency notify next kin:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Area Code and Phone Number: _(_____) _____

Second Emergency Contact (*Friend or relative NOT living with you*)

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Area Code and Phone Number: _(_____) _____

ADVANTIS HOME CARE INC

NOTIFICATION OF INTRODUCTORY PERIOD

EMPLOYEE: _____

JOB TITLE: _____

SOCIAL SECURITY NUMBER: _____

DATE OF HIRE: _____

PROBATORY DATE: _____ **TO** _____

I, _____, in accepting employment with the

Agency accepts and understands the first 90 days of employment will be considered my introductory period. If for any reason my employment is terminated during this period, I understand and accept this account will not be charged with any unemployment benefits I may be eligible to receive under the State Unemployment Compensation Law.

I also understand and accept that at the end of the 90 day period, I will receive written evaluation of my work performance. Should the Agency fail to provide this written evaluation, it shall be understood and accepted by all involved that the introductory period will have been completed satisfactorily.

Employee's Signature Date

Administrative Signature Date

ADVANTIS HOME CARE INC

CONFIDENTIALITY STATEMENT

I have been formally instructed regarding Agency policy and procedures for maintaining the confidentiality of all information contained in client/personnel files and records, as well as any other proprietary information regarding the agency that is obtained verbally.

I understand that, except as needed to conduct business, client and/or personnel information/proprietary information may not be discussed with anyone, either inside or outside the Agency.

I understand that medical records will not be removed from the Agency office unless the client has signed a "Release of Information Form", and the removal of such information is approved by the Agency Administrator and/ or designee.

I understand that any breach of confidentiality may be grounds for immediate termination of employment.

Employee

Date

Witness

Date

ADVANTIS HOME CARE INC

EMPLOYEE SAFETY CHECKLIST

Date: _____

Employee: _____

Employee will initial each box each instruction is completed and all questions/ concerns have been answered.

- | | |
|--|-----|
| 1. General Safety policy and program | [] |
| 2. Safety rules/general | [] |
| 3. Safety rules-specific to job | [] |
| 4. Employee counseling (discipline for safety policy violation) | [] |
| 5. Fire prevention, location of fire fighting equipment, and location of exits | [] |
| 6. Disaster Planning/Emergency Preparedness | [] |
| 7. How, when, and where to report injuries | [] |
| 8. Housekeeping and cleaning up spills | [] |
| 9. When and where to report unsafe conditions | [] |

On _____, I reviewed the above checked items relating the safety rules and safe work procedures for the Agency.

Employee

Signature: _____

Administrator/Designee Signature: _____

INDEPENDENT CONTRACTOR AGREEMENT

THIS AGREEMENT is effective as of _____, 20__ and is by and between, _____, a Florida corporation ("Company") and _____ ("Contractor").

RECITALS:

WHEREAS, the Company is primarily involved in the business of providing AGENCY Services to persons requiring these services; and

WHEREAS, the Company wishes to engage the Contractor and the Contractor wishes to be so engaged, to provide AGENCY Services to persons designated by the Company, as an independent contractor, upon the terms and conditions contained below;

NOW, THEREFORE, in consideration of these premises, mutual promises, covenants, terms and conditions contained herein, and other good and valuable considerations, the receipt and sufficiency of which are acknowledged by the parties, the parties agree as follows:

1. Services. Contractor shall provide, directly to AGENCY Services persons designated by the Company, services at such times and at such places as shall be agreed to between the Company and the Contractor. Contractor agrees that all patients are accepted for services only by the Company.

2. Compensation. The contractor shall be entitled to receive from the Company a payment with respect to each service provided by the Contractor to persons designated by the Company, which compensation is (and shall be paid) as set for under Exhibit "A" labeled and attached hereto and initialed by the parties hereto. Contractor shall not be entitled to any other compensation, and Contractor shall not be entitled to receive any reimbursement for any costs or expenses incurred by the Contractor. In connection with services provided by the Contractor, the Contractor shall prepare and provide to the Company, as may be reasonably requested, all reasonable documentation of such services in order that the Company, or any other entity designated by the Company, may comply with appropriate Federal and state laws with respect to the reimbursement by the Company, or such other entity, of the payments by the Company to the Contractor as compensation herein.

3. Contractor's Representations. Contractor represents to the Company that Contractor is, and will continue to be during the term of this Agreement, duly licensed as necessary in the State of Florida to provide the services hereunder, and the execution of this Agreement by the Contractor does not conflict with any other agreement to which the Contractor is a party. Contractor also represents that Contractor will perform hereunder without negligence and in compliance with all applicable laws including, without limitation, professional regulations. Contractor will dress appropriately while providing services.

4. Insurance. Contractor shall be responsible for obtaining and maintaining appropriate levels of professional liability insurance if applicable to cover the Contractor's performance hereunder. Contractor is required to provide Company a valid Certificate of Insurance reflecting professional liability insurance coverage immediately upon the request of Company.

In addition, Contractor is required to maintain automobile liability and personal injury protection insurance and shall provide proof of such insurance to the Company whenever requested.

Contractor must immediately notify Company if the Contractor's professional liability, automobile or PIP insurance is terminated, expires or is reduced, whether such action was initiated by the insurance Company or the Contractor.

5. Term. This Agreement shall commence as of the date first written above and shall continue for successive one (1) year terms, unless sooner terminated as follows: (i) this Agreement can be terminated by either party hereto upon thirty (30) days' written notice prior to the commencement of the successive one (1) year period; (ii) this Agreement may be pay compensated due to the Contractor hereunder within forty-five (45) days of the receipt by the Company of written notice of demand of same by the Contractor to the Company; (iii) this Agreement may be terminated by the Company at any time without notice in the event the Contractor breaches any covenant or representation under this Agreement, or (iv) this Agreement may be terminated at any time upon mutual written consent of the parties.

6. Independent Operation and Indemnity. This parties acknowledge that neither (i) the Contractor, nor (ii) the Company, or any of their affiliates (including, without limitation, principals, employees, agents and executive officers, if any), shall be deemed hereunder joint venturers, principals, partners, employees or agents of the other party hereto; provided all of the duties, obligations and responsibilities of the Contractor, and all activities with respect to the satisfaction of the foregoing, shall be conducted by the Contractor of the foregoing, shall be conducted by the Contractor independent of the Company as an independent contractor. The Contractor shall indemnify and hold the Company harmless from any and all claims of every kind and description whatsoever asserted against the Company arising out of the performance by the Contractor of Contractor's duties, obligations and responsibilities hereunder. Notwithstanding anything contained herein, the Contractor shall not be permitted to delegate any of the Contractor's duties hereunder to any employee, agent or other person without the written consent of the Company. The Contractor is not entitled to participate in any plans, arrangements or distributions of the Company in connection with any pension, stock, bonus, profit sharing or any other plans or benefits paid or made available to regular employees of the Company. Contractor shall have general control of Contractor's activities with the right to exercise independent good judgement as to the manner (but only as permitted hereunder) of servicing patients, customers and otherwise carrying out the provisions of this Agreement. In acting as an independent contractor

hereunder, Contractor shall be required to make arrangements for insurance, licenses and permits and for the payment of income taxes and social security taxes with regard to any payments received by Contractor and Contractor's services.

7. Restrictive Covenant and Confidentiality. All Statistical, financial and personal data relating to the patient which is confidential and which is clearly designated as such, will be kept in the strictest of confidence by Contractor and Company. Accordingly, Contractor agrees not to compete with Company for those patients and legal entities Contractor has serviced under this Agreement.

The Contractor acknowledges and agrees that information concerning the patients, suppliers, office files, procedures and policies, and other aspects of the business of the Company, is confidential, and in connection therewith, the contractor agrees not to use or disclose any such information at any time except as permitted under or as otherwise permitted in writing by the Company. The Contractor agrees to immediately surrender all such information in the possession or control of the Contractor, including all reproductions thereof, upon any termination of this Agreement.

The Contractor hereby agrees and acknowledges that (i) this Section and each of its provisions are reasonable as they relate to restrictions and limitations upon the Contractor, (ii) neither this Agreement nor this Section will operate as a bar to the Contractor's sole means of support, (iii) this Section may be enforced by the Company through use of an injunction or any other equitable remedy given the amount of damages to the Company for a breach of this Section, in addition to any other remedies the Company may have hereunder or under law, (iv) the Company shall be entitled to reimbursement from the Contractor for legal fees, costs and expenses incurred by the Company through all appeals, if any, to enforce this Section (v) this Section shall survive any termination of this Agreement; and (vi) if any provision of this Section is deemed unenforceable by a court of competent jurisdiction for whatever reason, such term shall be substituted with such term of immediately lesser duration or effect which shall be deemed enforceable.

8. Disclosure and Access. Contractor agrees and acknowledges that it will promptly notify Company, in writing, of any inquiries, investigations, complaints, and any disciplinary actions taken by any entity based on the Contractor's actions or inactions. Contractor hereby authorizes any entity regulating or supervising the Contractor to release to Company all information relating to such complaint or disciplinary action.

Contractor also agrees to provide Company access, upon request, to the Contractor's books, documents, and records. Contractor also agrees to allow federal and state agents access to books and records to verify the costs and reasonableness of the services furnished.

9. Third Party Beneficiaries. This Agreement has been entered into solely for the benefit of the parties hereto and in no event whatsoever shall any other party or parties be deemed a third party beneficiary or beneficiaries of this Agreement.

10. Company Responsibilities Under This Contract. Both Company and Contractor agree that the Company has the following responsibilities under this contract:

- a) admitting clients for services
- b) scheduling of appointments
- c) specifying types and time frames for Company required documentation to be completed and submitted to Company
- d) providing Contractor review of policies and procedures specifically addressing Contractor's qualifications and job duties/responsibilities
- e) client assessments, re-assessments, formulation and revision of plans and discharge planning, visit schedule. Contractor shall participate with Company in these activities as qualified and stipulated in Contractor's agreement.

11. Miscellaneous. This Agreement shall be governed by Florida law, with the sole venue for any action, suit or proceeding arising hereunder to be Dade County, Florida. No amendment to or assignment of this Agreement will be valid unless in writing and signed by the parties signing below. This Agreement may not be waived unless such waiver is in writing and signed by the waiving party. Each party acknowledges having been represented by independent legal counsel in connection with this Agreement or having waived such right. This Agreement sets forth the entire agreement of the parties as to the subject hereto and supersedes any prior agreement. Each party will execute such reasonable documents and take such reasonable action as may be reasonably requested to give effect to this Agreement. All costs and expenses of the parties in connection with this Agreement shall be borne by each such party incurring such costs and expenses. This Agreement may be executed in any number of counterparts.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

Witnesses:

Company

By: _____

Contractor:

By: _____

(Agree-dmc)

E X H I B I T A

M E D I C A R E

RN HOME HEALTH VISIT-----\$ _____ PER VISIT
LPN HOME HEALTH VISIT----\$ _____ PER VISIT
HHA HOME HEALTH VISIT----\$ _____ PER VISIT
PT HOME HEALTH VISIT-----\$ _____ PER VISIT
OT HOME HEALTH VISIT-----\$ _____ PER VISIT
ST HOME HEALTH VISIT-----\$ _____ PER VISIT
MSW HOME HEALTH VISIT--- \$ _____ PER VISIT

M E D I C A I D

RM HOM HEALTH VISIT-----\$ _____ PER VISIT
LPN HOME HEALTH VISIT----\$ _____ PER VISIT
HHA HOME HEALTH VISIT---\$ _____ PER VISIT
PT HOME HEALTH VISIT-----\$ _____ PER VISIT
OT HOME HEALTH VISIT-----\$ _____ PER VISIT
ST HOME HEALTH VISIT-----\$ _____ PER VISIT
MSWHOME HEALTH VISIT----\$ _____ PER VISIT

Job Title/Position: *Registered Nurse (RN)*

Reports To: *Clinical Supervisor*

JOB DESCRIPTION SUMMARY

The registered nurse plans, organizes and directs home care services and is experienced in nursing, with emphasis on community health education/experience. The professional nurse builds from the resources of the community to plan and direct services to meet the needs of individuals and families within their homes and communities.

ESSENTIAL JOB FUNCTIONS/RESPONSIBILITIES

Patient Care

1. Completes an initial assessment of patient and family to determine home care needs. Provides a complete physical assessment and history of current and previous illness(es).
2. Regularly re-evaluates patient nursing needs.
3. Initiates the plan of care and makes necessary revisions as patient status and needs change.
4. Uses health assessment data to determine nursing diagnosis.
5. Develops a care plan, which establishes goals based on nursing diagnosis and incorporates therapeutic, preventive, and rehabilitative nursing actions. Includes the patient and the family in the planning process.
6. Initiates appropriate preventive and rehabilitative nursing procedures. Administers medications and treatments as prescribed by the physician.
7. Counsels the patient and family in meeting nursing and related needs.
8. Provides health care instructions to the patient as appropriate per assessment and plan of care.
9. Identifies discharge planning needs as part of the care plan development and implements prior to discharge of the patient.
10. Acts as Case Manager when assigned by Clinical Supervisor and assumes responsibility to coordinate patient care for assigned caseload.

Communication

1. Prepares clinical notes and updates the primary physician when necessary and at least every sixty days.

Job Title/Position: *Registered Nurse (RN)*

2. Communicates with the physician regarding the patient's needs and reports any changes in the patient's condition; obtains/receives physician's orders as required.
3. Communicates with community health related persons to coordinate the care plan.

Additional Duties

1. Participates in on-call duties as defined by the on-call policy.
2. Ensures that arrangements for equipment and other necessary items and services are available.
3. Instructs, supervises and evaluates home health aide care provided every two (2) weeks.

POSITION QUALIFICATIONS

1. Registered nurse with current licensure to practice professional nursing in the state.
2. Graduate of National League for Nursing accredited school of nursing.
3. Maintains a current CPR certification.
4. Current valid driver's license.
5. Minimum of two years experience, at least one of which is in the area of public health or home care nursing is preferred.
6. Self directed and able to work with minimal supervision.
7. Demonstrates excellent observation, problem solving, verbal and written communication skills; nursing skills per competency checklist.
8. Shows ability to organize and prioritize workload independently.
9. Management experience not required. Responsible for supervising home health aides.
10. Prolonged or considerable walking or standing. Able to lift, position, or transfer patients. Able to lift supplies and equipment. Considerable reaching, stooping, bending, kneeling, or crouching. Visual acuity and hearing to perform required nursing skills.

ADVANTIS HOME CARE INC.
ORIENTATION CHECKLIST FOR FIELD STAFF

Employee Name: _____ Title: _____ Hire Date: _____

I. GENERAL ORIENTATION

_____ Agency Mission/Goals/Philosophy/Organizational Structure/Lines of Authority

_____ Tour of Agency:

- _____ a) Location of administrative offices
- _____ b) Location of Fire Extinguishers
- _____ c) Location of Emergency Lights/Exits
- _____ d) Location of First Aid Box
- _____ e) Emergency Evacuation/Escape Routes

_____ Standards of Ethical Conduct/Ethical Issues

_____ Conflict of Interest

_____ Scope of Services/Organizational Chart

_____ Job Descriptions/Skill Competencies/Evaluations

_____ Training specific to Job Requirements

_____ Personnel File Requirements/Malpractice Coverage

_____ Written Policies and Procedures

_____ Transfer and Discharge Policies

_____ Complaint Policy/Handling of patient grievances/complaints

_____ Nondiscrimination Policy/Sexual Harassment Act/

_____ Payroll Policies/Salary/Hourly Wage/Hours of Work

_____ Use of ID Badges

_____ Compliance Program/Medicare/Medicaid Fraud and Abuse

_____ Cultural Diversity and Sensitivity

_____ Communication Barriers

_____ Professional Boundaries

_____ Interpreters/Communicating with hearing/speech/visually impaired

II. CLINICAL ORIENTATION

_____ Clients Rights and Responsibilities/Advance Directives

_____ Patient Assignments/Cancellations Policies/Missed Visit Reports

_____ Medical Emergencies

_____ QAPI Program and role/Clinical Record Reviews

_____ On Call Policy

_____ Documentation Requirements/ Submission Timeframes/Record keeping & Reporting

_____ Clinical Records Contents/Retention/Maintenance

_____ Oasis Assessments/ Visit Documentation/Admission Forms

_____ Client Admission/Transfers/Discharge Policies

_____ Client referrals to another Agency

_____ Abuse/Neglect Screening and Reporting

_____ Conveying of Charges for Care/Services

_____ Staff Education/In-service Requirements

_____ Pain Assessment and Management

_____ Supervisory Visits

_____ Other: _____

III. CONFIDENTIALITY

- _____ Client/Family/Significant Other
- _____ Staff Information
- _____ HIPPA Privacy Rule/Notice of Privacy Practices/Confidentiality and Privacy of PHI
- _____ Agency Business Information

IV. SAFETY/ RISK MANAGEMENT/INFECTION CONTROL

- _____ Unusual Occurrences/Incidence/Variance Reporting
- _____ Fall Reduction Program
- _____ Employee Safety Management Training Program: (Body Mechanics/Lifting/Security/In-home Safety/Environmental Hazards/ Fire/Evacuations/Office & Patient Care Equipment (Use/Maintenance/Cleaning and Disinfection)/Personal Safety Techniques
- _____ OSHA Requirements/Right to know Laws
- _____ Infection Control and Prevention Guidelines/Hand Hygiene/Standard Precautions/Bag Technique/PPE/Blood-borne Pathogens/Hepatitis/ Influenza Vaccination
- _____ Biomedical/Bio-hazardous/Infectious Waste Management: Identification/Disposal/Transportation of Waste)
- _____ Environment of Care (Patient and Agency Site)
- _____ Communicable Infections: AIDS/Tuberculosis/TB Post-Exposure Plan
- _____ Emergency/Disaster Preparedness Plan
- _____ Disaster Plan/Fire Drills
- _____ Safe Medical Device Act/MSD
- _____ Other: _____
- _____ Other: _____

DECLARATION

____ I have read and understand the policies and procedures for this agency and have had the opportunity to have all of my questions/concerns addressed to my complete satisfaction. I further acknowledge receipt of the Agency Employee Handbook.

____ I agree to abide by and uphold all rules, conditions, policies and procedures, and have been advised that failure to do so may result in termination of employment/contract

____ I also agree that as requirement of employment/contract, regardless of status, (E.g. full time, part time, per Diem, etc.), I will provide the agency with a fourteen (14) day written notice of intent to terminate employment.

Date orientation completed: _____

Employee Signature/Title

Date

Supervisor Signature/Title

Date

Supervisor Signature/Title

Date

ADVANTIS HOME CARE INC

NAME: _____ POSITION: _____ Date: _____

1. What should be reported for Compliance Training?
 - a. Fraud and Abuse
 - b. Violation of the law, regulation, policies and procedure
 - c. All of the above
 - d. None of the above

2. What are examples of Compliance issues?
 - a. Helping a patient
 - b. Bribes or kicks backs
 - c. Billing the correct amount for the services provided
 - d. All of the above

3. An employee can accept gifts and tips from patients and their families.
 - a. True
 - b. False

4. Who can report any issues to?
 - a. An employee
 - b. Corporate Compliance Officer
 - c. The patient
 - d. None of the above

5. When you become aware of any issues related to Corporate Compliance an employee should report it.
 - a. True
 - b. False

6. Once reported, the information will be kept confidential.
 - a. True
 - b. False

7. Paying a physician to refer patients is considered a Conflict of Interest.
 - a. True
 - b. False

8. All complaints are considered confidential and anonymous
 - a. True
 - b. False

ADVANTIS HOME CARE INC

NAME: _____ POSITION: _____ Date: _____

Circle the correct answer:

1. T F We must abide by the HIPPA Privacy Rule only because it is a condition of participation for the Medicare Program
 2. T F Written, oral and electronic information are all forms of PHI protected by the Privacy Rule
 3. T F As an employee of a covered entity, I am required to do all that I can to safeguard PHI from unauthorized use and disclosures.
 4. T F The minimum necessary standard requires that I use the least amount of PHI necessary to perform my job duties.
 5. T F There are civil as well as criminal penalties for non-compliance.

 6. The purpose of the Privacy Rules is to:
 - a. Protect PHI from unauthorized uses and disclosures.
 - b. Give health care consumers more control over uses and disclosures of their health information.
 - c. Provide a baseline of privacy protection to all healthcare consumers
 - d. A and C only
 - e. All of above

 7. Under the Privacy Rule, patients have the right to:
 - a. Amend health information.
 - b. Receive a copy of the Notice of Privacy upon admission.
 - c. Request restrictions on the uses and disclosures of their health information
 - d. A and C only
 - e. All of above

 8. Privacy policies and procedures of the agency:
 - a. May be revised when there is a change in the law governing such policies.
 - b. Are discussed with staff upon hire and whenever there is a change.
 - c. Details how the agency complies with the requirements of the Privacy Rule.
 - d. B and C only
 - e. All of above

 9. Failure to comply with the agency's privacy policies and procedures:
 - a. May lead to termination
 - b. Is ok under certain conditions
 - c. Do not apply to contracted staff
 - d. Must only be adhered to by clinical staff

 10. The administrative Simplification provisions of HIPPA include:
 - a. Transaction Rule
 - b. Security Rule
 - c. Privacy Rule
 - d. B and C only
 - e. All of the above
-

Emergency Management Plan Post Test

1. An emergency is any situation that disrupts or alters the normal day to day business.

True or False

2. Who will make the decision to implement the plan?

- a. The Administrator
- b. The Board of Directors
- c. The Administrator or designee

3. The Agency is required to provide care regardless of the situation.

True or False

4. The policies relating to Emergency Management is located in:

- a. Administrative Policies
- b. Patient Care Policies
- c. Disaster Manual

5. When are employees oriented to the plan?

- a. When the disaster occurs
- b. On hire
- c. Within 90 days of hire

6. How often is the plan reviewed and updated?

- a. Yearly
- b. Every 6 months
- c. Yearly and when the plan is implemented

7. On admission the patient/client is assigned an emergency classification. What are the classifications?

- a. 1-3
- b. I through IV
- c. A-D

8. Patient's with special needs will be registered with local shelters.

True or False

9. During an emergency _____ is a primary concern.

- a. Maintaining phone contact
- b. Securing the office
- c. Staff safety

10. How should the employee prepare for an emergency?

- a. Know the Agency's plan
- b. Have the automobile equipped
- c. Establish a family plan
- d. All of the above

ADVANTIS HOME CARE INC

EMPLOYEE STATEMENT REGARDING DENIAL OF T.B. SIGNS & SYMPTOMS

EMPLOYEE/CONTRACTOR NAME: _____ Title: _____

Circle any of the Tuberculosis symptoms below that you are experiencing at this time:

- Chronic Cough
- Unusual fatigue or weakness
- Night Sweats
- Continued Low Grade Fever
- Loss of Weight
- Loss of Appetite
- Coughing up Blood

I have read the above information and understand that if I am experiencing or experience the above symptoms, I will contact my agency supervisor immediately, and I will need to go for a medical evaluation by private physician, as soon as possible.

Employee/Contractor Signature

Date

INFLUENZA VACCINATION DECLARATION

I UNDERSTAND THAT AS A PATIENT CARE STAFF, CONTRACT STAFF AND LIP, I CAN ACQUIRE AND TRANSMIT INFLUENZA FROM TO PATIENT AND OTHER STAFF.

THE AGENCY HAS ENCOURAGED ME TO OBTAIN/SEEK INFLUENZA VACCINE FROM MY CARE PORVIDERS OR HEALTHCARE PROVIDERS WHO PROVIDE THE VACCINE (I.E PHARMACIES, LOCAL HEALTH DEPARTMENTS, ETC).

A LIST OF COMMUNITY RESOURCES WITH INFORMATION PERTAINING WHERE TO OBTAIN THE VACCINE HAS BEEN PROVIDED.

HAVING BEEN INFORMED :

I, _____, STATE THAT I HAVE BEEN VACCINATED (INFLUENZA) BY A HEALTH CARE PROVIDER FOR THIS CURRENT YEAR INFLUENZA SEASON .

I, _____, DECLINE TO BE VACCINATED AGAINST INFLUENZA FOR THESE REASONS:

_____ ALLERGIES

_____ UNWANTED SIDE EFFECTS

_____ RELIGIOUS REASONS

_____ FINANCIAL REASONS (DOES NOT WISH TO PAY FOR THE VACCINE)

_____ DOES NOT WANT TO

NAME PRINT _____

SIGNATURE _____ DATE _____

ADVANTIS HOME CARE INC

HEPATITIS B VACCINATION CONSENT

- I have read the information concerning Hepatitis B vaccination.
- I understand the benefits and risks of the Hepatitis B vaccination and have had the opportunity to ask questions.
- The vaccine will be administered in a series of three (3) doses: the initial dose, the second dose a month later, and the last dose six months after the first. I understand I must complete the series for full immunization.
- If I receive the vaccine, I have a 90-95% chance of developing antibodies to the Hepatitis B surface antigen and therefore immunity to the infection of the Hepatitis B virus.
- The vaccine may not be effective, if I am already incubating the Hepatitis B virus.
- The duration of immunity is unknown at this time and I may require a booster in five (5) years
- The vaccine only protects against Hepatitis B virus and does not confer immunity against the Hepatitis A or non-A/non-B agents.
- After receiving the vaccination minor side effects, such as infection site soreness and redness, low-grade fever, malaise and nausea, have been reported.

I, _____, request vaccination with the Hepatitis B vaccine.

I, _____, decline vaccination with the Hepatitis B vaccine.

By also doing, understand that due to my occupation's exposure to blood or other infectious materials, I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself. However, I decline the vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If in the future I choose to be vaccinated with the hepatitis B Vaccine, I can receive the vaccine series at no charge at that time.

Signature

Date

Witness

Date



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>

*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.*

1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____	QR Code - Section 1 Do Not Write In This Space
---	---

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



Employer Completes Next Page





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
-------------------------------------	-------------------------	-------------------------	------	--------------------------------

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.

Request for Taxpayer Identification Number and Certification

**Give Form to the
 requester. Do not
 send to the IRS.**

▶ Go to www.irs.gov/FormW9 for instructions and the latest information.

	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
	2 Business name/disregarded entity name, if different from above	
Print or type. See Specific Instructions on page 3.	3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____ Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) ▶ _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i>
	5 Address (number, street, and apt. or suite no.) See instructions.	Requester's name and address (optional)
	6 City, state, and ZIP code	
	7 List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)																																																																							
Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see <i>How to get a TIN</i> , later. Note: If the account is in more than one name, see the instructions for line 1. Also see <i>What Name and Number To Give the Requester</i> for guidelines on whose number to enter.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="10" style="text-align: center;">Social security number</td> </tr> <tr> <td style="width: 20px;"> </td><td style="width: 20px;"> </td> </tr> <tr> <td colspan="4" style="text-align: center;">-</td> <td colspan="2" style="text-align: center;">-</td> <td colspan="4"></td> </tr> <tr> <td colspan="10" style="text-align: center;">or</td> </tr> <tr> <td colspan="10" style="text-align: center;">Employer identification number</td> </tr> <tr> <td style="width: 20px;"> </td><td style="width: 20px;"> </td> </tr> <tr> <td colspan="4" style="text-align: center;">-</td> <td colspan="2" style="text-align: center;">-</td> <td colspan="4"></td> </tr> </table>	Social security number																				-				-						or										Employer identification number																				-				-					
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Part II Certification	
Under penalties of perjury, I certify that:	
1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and 3. I am a U.S. citizen or other U.S. person (defined below); and 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.	
Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.	
Sign Here	Signature of U.S. person ▶ _____ Date ▶ _____

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-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

Form W-4 (2019)

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 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 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 2019 expires February 17, 2020. 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 2019 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 not subject to withholding 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 2019. 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 filing jointly 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 not subject to withholding, 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 Additional 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 may 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 may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. 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 if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. 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

----- 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 2019	
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 2019, 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 7					
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
Employee's signature (This form is not valid unless you sign it.) ►				Date ►	
8 Employer's name and address (Employer: Complete 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)	

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line G. Other credits. You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). 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. Enter “-0-” on lines E and F if you use Worksheet 1-6.

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 not subject to withholding, 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/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 \$71,201 (\$103,351 if married filing jointly), enter "4" for each eligible child.
 - If your total income will be from \$71,201 to \$179,050 (\$103,351 to \$345,850 if married filing jointly), enter "2" for each eligible child.
 - If your total income will be from \$179,051 to \$200,000 (\$345,851 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.** See Pub. 972, Child Tax Credit, for more information.
 - If your total income will be less than \$71,201 (\$103,351 if married filing jointly), enter "1" for each eligible dependent.
 - If your total income will be from \$71,201 to \$179,050 (\$103,351 to \$345,850 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 \$179,050 (\$345,850 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. If you use Worksheet 1-6, enter "-0-" on lines E and F 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 not subject to withholding 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 \$53,000 (\$24,450 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 not subject to withholding.

- 1 Enter an estimate of your 2019 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$1,000), and medical expenses in excess of 10% of your income. See Pub. 505 for details 1 \$ _____
- 2 Enter:
 - \$24,400 if you're married filing jointly or qualifying widow(er)
 - \$18,350 if you're head of household
 - \$12,200 if you're single or married filing separately2 \$ _____
- 3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" 3 \$ _____
- 4 Enter an estimate of your 2019 adjustments to income, qualified business income deduction, 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 2019 nonwage income not subject to withholding (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 \$4,200 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 of that worksheet on 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 2019. 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 2019. 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 - \$24,900	\$420	\$0 - \$7,200	\$420
5,001 - 9,500	1	7,001 - 13,000	1	24,901 - 84,450	500	7,201 - 36,975	500
9,501 - 19,500	2	13,001 - 27,500	2	84,451 - 173,900	910	36,976 - 81,700	910
19,501 - 35,000	3	27,501 - 32,000	3	173,901 - 326,950	1,000	81,701 - 158,225	1,000
35,001 - 40,000	4	32,001 - 40,000	4	326,951 - 413,700	1,330	158,226 - 201,600	1,330
40,001 - 46,000	5	40,001 - 60,000	5	413,701 - 617,850	1,450	201,601 - 507,800	1,450
46,001 - 55,000	6	60,001 - 75,000	6	617,851 and over	1,540	507,801 and over	1,540
55,001 - 60,000	7	75,001 - 85,000	7				
60,001 - 70,000	8	85,001 - 95,000	8				
70,001 - 75,000	9	95,001 - 100,000	9				
75,001 - 85,000	10	100,001 - 110,000	10				
85,001 - 95,000	11	110,001 - 115,000	11				
95,001 - 125,000	12	115,001 - 125,000	12				
125,001 - 155,000	13	125,001 - 135,000	13				
155,001 - 165,000	14	135,001 - 145,000	14				
165,001 - 175,000	15	145,001 - 160,000	15				
175,001 - 180,000	16	160,001 - 180,000	16				
180,001 - 195,000	17	180,001 and over	17				
195,001 - 205,000	18						
205,001 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.

ADVANTIS HOME CARE INC

PHYSICAL EXAMINATION FORM

In my opinion, _____

Is physically and mentally able to perform the duties of _____

The above patient appears to be free of communicable disease including tuberculosis and does not constitute a risk of communication disease to any person under the care of the Agency.

Physician Signature

Date

Physician Print Name: _____

Address: _____

Phone Number: _____

TUBERCULIN SKIN TEST OR CHEST XRAY

Test Date: _____

Type: _____

Reading Date: _____

Negative: _____ Positive: _____

Employee Training: Emergency Operations Plan (EOP)

Employee Name: _____ Initial _____ Annual Training

I have received Emergency Preparedness Plan training and I have had the opportunity to ask questions regarding this training.

Emergency Preparedness Plan Reviewed

Risk Assessment and Emergency Planning

Community-Based and Facility-Based (Agency) Risk Assessment presented.

Strategies addressing emergency events identified by the risk assessment.

Emergency Policies and Procedures

Roles explained

Safety and Cooperation discussed

Communication Plan

Communication plan reviewed and discussed.

Training and Testing

Testing/implementation of plan and staff roles reviewed and discussed:

Employee Protection Plan

Business Continuation Plan

Comments:

____ Yes ____ No Employee was deemed competent with the EOP.

Employee Signature: _____ Date: _____

Instructor Signature: _____ Date: _____



ADVANTIS HOME CARE, INC.
HANDWASHING
COMPETENCY EVALUATION

Employee Name: _____

Title: _____

Items	Yes No N/A OBSERVED	Comments
1. Wets hands and wrists completely: points fingers downward		
2. Applies soap over entire hand/wrist area; lathers well		
3. Scrubs hands and wrists well, paying attention to fingernails and between fingers.		
4. Rinses well, keeping fingers pointed downward		
5. Dries hands and wrists completely using a paper towel or a clean hand towel		
6. Turns off faucet with the paper towel or cloth towel		
7. If no running water or Handwashing Facilities not available, uses a Packaged Handwashing product or Hand sanitizer		
<p>Compliance with CDC guidelines: monitoring of the staff at key points in time such as : before patient contact; after contact with blood, body fluids, after contact with contaminated surfaces (even if gloves are worn); before invasive procedures; after removing gloves.</p>		
<p>Staff follow all CDC guidelines at time of evaluation and during supervisions or joint visits</p>		

Additional Comments: _____

Signature/Title of Evaluator: _____

Date: _____

INITIAL COMPETENCY CHECKLIST
RN/LPN

NAME _____ RN _____ LPN _____

Date _____

Date and RN's signature indicates that the nurse has been checked off on the procedure.

SKILLS	COMPETENT		COMMENTS	DATE & INITIAL
	YES	NO		
1. Urinary catheters:				
a. Foley insertion–male/female				
b. Suprapubic insertion/removal				
2. Central Cath Lines				
3. Enteral Feedings:				
a. Bolus				
b. Continuous				
c. Removal/insertion PEG tubes				
4. Equipment:				
a. IV pumps				
b. Enteral pumps				
c. Oxygen concentrator				
d. Oxygen tank				
e. Nebulizer				
5. IV therapy:				
a. Peripheral/INT				
b. Adm fluids/meds				
c. Dressing change				
6. Irrigations:				
a. Bladder				
b. Colostomy				

Initial Competency Checklist RN/LPN/LVN...continued

SKILLS	COMPETENT		COMMENTS	DATE & INITIAL
	YES	NO		
7. Suctioning:				
a. Nasal				
b. Oral				
c. Tracheal				
8. Tracheostomy Care				
9. TPN:				
a. Administration				
b. Labs				
c. Starting/stopping				
d. Additives				
10. Venipunctures				
11. Transporting lab specimens				
12. Wound care:				
a. Aseptic technique				
b. Sterile technique				
13. Standard Precautions:				
a. Gloves				
b. Gowns				
c. Masks/goggles				
d. Shoe covers				
e. CPR resuscitation masks				

DATE OF INITIAL COMPLETION: _____

Employee Signature/Title

Observer Signature/Title

PERFORMANCE EVALUATION

Job Title/Position: <i>Registered Nurse</i>		Page 1
Date:		
Reviewer: <input type="checkbox"/> Annual <input type="checkbox"/> 90 Day <input type="checkbox"/> Other		
<p style="font-size: small;">Key: 4 = Superior Performance 3 = Satisfactory Performance 2 = Inconsistent Performance 1 = Unacceptable Performance</p>		
<p>A. Patient Care Responsibilities</p> <p style="padding-left: 20px;"><i>Patient Care</i></p> <ol style="list-style-type: none"> 1. Completes an initial assessment of patient and family to determine home care needs. Provides a complete physical assessment and history of current and previous illness(es). 2. Regularly re-evaluates patient nursing needs. 3. Initiates the plan of care and makes necessary revisions as patient status and needs change. 4. Uses health assessment data to determine nursing diagnosis. 5. Develops a care plan that establishes goals, based on nursing diagnosis and incorporates therapeutic, preventive, and rehabilitative nursing actions. Includes the patient and the family in the planning process. 6. Initiates appropriate preventive and rehabilitative nursing procedures. Administers medications and treatments as prescribed by the physician. 7. Counsels the patient and family in meeting nursing and related needs. 8. Provides health care instructions to the patient as appropriate per assessment and plan. 9. Identifies discharge planning needs as part of the care plan development and implements prior to discharge of the patient. <p style="padding-left: 20px;"><i>Communication</i></p> <ol style="list-style-type: none"> 1. Prepares clinical notes and updates the primary physician when necessary and at least every sixty days. 2. Communicates with the physician regarding the patient's needs and reports any changes in the patient's condition; obtains/receives physician's orders as required. 3. Communicates with community health related persons to coordinate the care plan. <p style="padding-left: 20px;"><i>Additional Duties</i></p> <ol style="list-style-type: none"> 1. Participates in on-call duties as defined by the on-call policy. 2. Ensures that arrangements for equipment and other necessary items and services are available. 3. Instructs, supervises and evaluates home health aide care provided every two (2) weeks. <p>Targeted Goals For Next Review Cycle:</p> <p>_____</p> <p>_____</p> <p>Comments:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Rating</p> <p>1 2 3 4</p>	

Reviewer: _____ Date: _____
 Name of Personnel: _____ Date: _____

