CARING HANDS HOME CARE INC
COMPASSIONATE SKILLED SERVICES

Employment Application/Agreement

Fill out this form in its entirety.
When completed, click on the ***SUBMIT*** button below.

SUBMIT ▶

Manually Email: When completed, save the PDF and email it to;
yourcareer@chhc1.com

Suffolk
263 Blue Point Avenue
Blue Point, New York. 11715
Phone: 631-419-6737
Fax: 631-868-3498

Nassau
4238 Merrick Road
Massapequa, New York. 11758
Phone: 516-900-1977
Fax: 516-900-1978

Queens
222-15 Northern Blvd.
Bayside, New York. 11361
Phone: 718-225-1414
Fax: 718-225-1415

Thank you for expressing an interest in Caring Hands Home Care. You are required to bring the following items listed below with you at the time of you interview. Please complete all the paperwork to the best of your ability. Prompt completion of all paperwork will facilitate a smooth interview process.

We look forward to meeting you!

Brigit Durkin, R.N. Administrator, Robert Pacella CEO

Please bring the following with you on day of Interview:

- Employment Application
- Resume
- Two previous employer references
- Nursing Skills Checklist
- 2 Passport Photos
- Medical Cover Sheet
- Medical History Questionnaire
- Copy of Titers
- Evidence of Flu Shot or declination will be obtained

Please bring the original document as well as a COPY of the following:

- Nursing Registration (with license number and expiration date)
- Malpractice Insurance Certificate
- Control Certification (Infection)
- CPR certification
- Social Security Card
- NYS Driver License and or Passport/ Alien Registration Card with photo

CARING HANDS HOME CARE INC
COMPASSIONATE SKILLED SERVICES

EMPLOYMENT APPLICATION/AGREEMENT

Please complete all the information on this form and sign on the last page. A representative from Caring Hands Home Care ("CHHC") will also sign this form when you are done. When this Application is fully signed it will become your Employment Agreement.

NAME: _____ SOCIAL SECURITY # _____

Present Address: 1 _____

_____ 1 1 1 _____

Home Telephone: 1 _____ Work or Alternate: _____

Previous Address:

_____

_____

Position(s) Applied for: 1. _____

2. _____

Have you worked for us before? _____ If yes, when? _____

If hired, on what date would you be available to work? _____

If driving is required of this position:

Do you have a reliable means of transportation? Yes _____ No _____

Do you have a current valid NY State driver's license? Yes _____ No _____

Driver's License No.? _____

Are you currently covered by auto liability insurance? Yes _____ No _____

Insurance carrier? Yes _____ No _____

Any objection to travel, if required to by job? Yes _____ No _____

If you have alien status and are hired, can you provide written evidence of your right to work in the United States?

Yes _____ No ____

CARING HANDS HOME CARE INC
COMPASSIONATE SKILLED SERVICES

PRIOR WORK HISTORY

1. From: _____ To: _____ Position: _____

Name of Employer: _____

Address: _____ Phone:_____

Summary of Job duties: _____

_____

Dislikes about job: _____

Starting salary: _____ Ending salary: _____

Immediate supervisor's name: _____ Title: _____

Reason for wanting a job change: _____

_____

2. From: _____ To: _____ Position: _____

Name of Employer: _____

Address:_____ Phone: _____

_____

Summary of Job duties: _____

Dislikes about job: _____

Starting salary: _____ Ending salary: _____

Immediate supervisor's name _____ Title _____

Reason for wanting a job change: _____

CARING HANDS HOME CARE INC
COMPASSIONATE SKILLED SERVICES

EDUCATIONAL BACKGROUND

Type of School	Name of School	City/State	Years Attended	Graduated Yes	Graduated No	Course/Major
Grammar or Grade School						
High School						
Junior College						
College						
Post Graduate						
Business or Trade						
Military Service						

PROFESSIONAL LICENSURE AND MEMBERSHIP

NEW YORK STATE LICENSURE:

Date License originally obtained: _____ License Number: _____

Do you hold licenses in other states? Yes ☐ No ☐

If yes, state and number: _____

PROFESSIONAL AFFILIATIONS:

Are you a member of any professional organization? Yes ☐ No ☐

Names of professional organizations to which you belong?

_____ _____

_____ _____

Have you been the subject of any disciplinary action by a state agency of New York State or any other state? Yes ☐ No ☐

If so, please explain: _____

Have you ever been the subject of any ethics investigation by any professional organization?

Yes ☐ No ☐

If so, please explain: _____

Have you ever had a claim or any threat of a claim against you arising out of conduct in the provision of any health care service or practice of a profession?

Yes ☐ No ☐

EQUIPMENT USED

I have used the following equipment and I'm competent to use this equipment: Please say Yes or No to the equipment you have used and state when you have last used this equipment.

Ventilators:	Apnea Monitor:
Oximeter:	Oxygen:
I.V. :	Other:
Other:	Other:

EMPLOYMENT CAPABILITIES

Please list any reason known to you as to why you might be unable to perform consistently and promptly any of the job duties:

_____

Is there any reason why you may not be able to accept employment, if offered. with this company?

Yes ☐ No ☐ If yes, please explain _____

Have you ever been convicted of a crime, excluding minor traffic offenses? Yes ☐ No ☐

If yes, please provide details: _____

Have you ever been disciplined or fired? Yes ☐ No ☐

Do you have any objections to occasional overtime? Yes ☐ No ☐

CHHC POLICY AND PROCEDURES MANUAL

The CHHC Policy and Procedures Manual is part of your Employment Agreement and should be reviewed carefully.
I reviewed the CHHC Policy and Procedures Manual and understand its contents: Yes ☐ No ☐

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW SIGNIFYING YOUR UNDERSTANDING AND ACCEPTANCE.

1. I will provide all services on behalf of CHHC Employer faithfully and in compliance with all applicable Federal. State and local laws, rules and regulations and the rules, policies and procedures of CHHC, as adopted from time to time, whether orally or in writing.
2. I understand that my duties shall include the maintenance of all records, intake and other forms, reports, claims and correspondence as required by professional practice standards, law. regulation, third-party payors, managed care organizations or CHHC.
3. I will immediately notify CHHC of any investigation or charges by a New York State agency or agency off any state, an ethics complaint by any professional organization, or any arrest or conviction in any state. Failure to notify CHHC may result in the loss of employment.
4. I understand my employment by CHHC may be terminated for any of the following reasons:
    - embezzlement. theft. larceny, material fraud, or other acts of dishonesty:
    - material violation by employee of any of his/her obligations under this Agreement;
    - conviction of or entrance of a plea of guilty or nolo contendere to a felony or other crime which has or may have a material adverse effect on my ability to carry out my duties under this Agreement or upon the reputation of CHHC: conduct involving moral turpitude;
    - gross insubordination or repeated insubordination;
    - the revocation of my professional licensure in any State and/or revocation of Medicare or Medicaid participation, as applicable, whether it be suspended, revoked. or otherwise restricted or terminated:
    - the provision or attempt to provide, services while under the influence of alcohol, drugs. or other mood altering substances (except as duly prescribed by a treating physician and taken in accordance with the prescription):
    - engaging in any conduct reasonably deemed by CHHC, in its sole discretion, to be injurious to its best interests;

- material and continuing failure by the Employee to perform the duties described in this Agreement in a quality and professional manner: and
- determination by CHHC, in its sole discretion, that CHHC may have engaged in unprofessional conduct, or criminal, unethical, or fraudulent conduct of any nature

5. **Non-Compete**

   - I understand that CHHC has spent considerable time and resources in building its business and in obtaining patients, including patients for whom I will be referred by CHHC to provide care. I further understand that should a nurse who provides care to a patient of CHHC provide care to that patent privately or through another entity instead of through CHHC, CHHC will incur loss of income and possibly other damages. Accordingly, I agree that during my term of employment by CHHC and for two years after the termination of such employment with CHHC for any reason, I shall not provide services to any current, former, or future patient of CHHC either privately or through any business in which I am or will be a participant, in any capacity whatsoever, nor shall I induce, attempt to persuade or solicit any former, current or future patient of CHHC to terminate his/her relationship with CHHC in order to enter into any relationship with me, any business in which I am or will be a participant, in any capacity whatsoever, or any other business in competition with CHHC's business.
   - As the damages to CHHC will be difficult to calculate should I breach any provision of this paragraph above, I agree that should I breach any provision I shall pay CHHC the liquidated damages amount of $10,000, in addition to any actual damages to be determined, and shall pay any and all attorney's fees CHHC may incur in the enforcement of this Agreement, regardless of whether CHHC prevails in such action.
   - I acknowledge that this non-compete restriction is reasonable as to extent and duration, that it is fully enforceable, and waives any objection thereto and I covenant to institute no suit or proceeding or otherwise advance any position or contention to the contrary. These provisions and warranties shall survive the termination of this Agreement.

6. I hereby certify that the answers given by me to all the questions mentioned on this application form are true and correct. If employed by the CHHC, I will comply with all rules and regulations of CHHC. I also authorize my former employers to give any information they have regarding me, whether or not it is on their records. I hereby release them and the CHHC from all liability for any damage whatsoever for issuing it. If upon investigation, anything in this application is found to be untrue, or if I do not pass the physical examination, if required, I understand I will be subject to dismissal.

Date: _____ Signature of Employee _____

Date: _____ Signature of CHHC Representative _____

CARING HANDS HOME CARE INC
COMPASSIONATE SKILLED SERVICES

Job Description

Job Title: Licensed Practical Nurse (LPN)

Reports to the Supervising RN Position Summary:

The LPN functions in a dependent role at the direction of the Registered Nurse (RN). Under RN direction the LPN administers medications, provides nursing treatments and gathers patient measurements, signs, and symptoms that can be used by the RN in making decisions about the nursing care of patients. The LPN ensures the quality and safe delivery of home health care services and provides compassionate care that is respectful of each patient's needs, values and wishes.

Position Qualifications:

- Must be a graduate of an accredited school of nursing
- Must be a currently licensed LPN through NYS nursing board
- Complies with accepted professional standards and principles
- Experience in home health care or related field preferred
- Good verbal and written communication skills required

Physical Requirements:

- Must be able to speak and hear in a manner understood by most persons
- Must be able to travel to patients place of residence
- Must be able to stoop, bend, lift and transfer patients
- Must be able to deal effectively with stress

Duties and Responsibilities

- Ensures quality and safe delivery of home health care services
- Follows the patients plan of care as developed by the RN and provides quality nursing care that reflects the patients plan of care
- Immediately calls the Supervising RN with any changes in patients' medical condition or medications initial_____
- Completes, maintains and submits all nursing documentation forms in a timely manner and according to the agency policies and procedures
- LPN's work under the direction of the RN and do not perform assessments. LPN's monitors, records, and reports patient findings to the RN
- Participates in patient case conferences
- Provides and maintains a safe environment for the patient
- Maintains consistent lines of authority
- Adheres to HIPPA guidelines and maintains confidentiality of patient information as per agency policies and procedures initial _____

- Implements infection control and safety measures as per agency policies and procedures
  initial_____

- Demonstrates accurate effective and efficient use of equipment and supplies and reports malfunctioning equipment and inadequate supplies to Supervising RN immediately
- Complies with all agency policies and procedures
- Participates in personal professional growth and development

I acknowledge that I have read and understand the requirements and responsibilities associated with this job description.

Print Name _____

Signature _____ Date _____

Supervising RN/Coordinator _____

Signature _____ Date _____

CARING HANDS HOME CARE INC
COMPASSIONATE SKILLED SERVICES

Job Description

Job Title: Registered Nurse (RN)

Reports to the Supervising RN and the Director of Nursing

- **Position Summary:** The RN provides skilled professional nursing care to home care clients as prescribed by the Physician and in compliance with regulations as established by the New York State Nursing Board. The RN is responsible for the delivery of patient care services through coordination, implementation and supervision of patients. The RN ensures quality and safe delivery of home care services. The RN follows the Medical Plan of Treatment. The RN participates in Quality Improvement activities within the Agency promoting overall compliance with State and Federal guidelines and professional standards of practice.

Position Qualifications:

- Must be a graduate of an accredited school of nursing
- Must be a currently licensed RN through NYS nursing board
- Must have at least 1 year of clinical experience. Home care or public health nursing preferred
- Complies with accepted professional standards and principles
- Possesses good verbal and written communication skills
- Possesses good organizational and leadership skills
- Is self-directed, dependable, flexible and cooperative in fulfilling the role

Physical Requirements:

- Must be able to hear and speak in a manner understood by most persons
- Must be able to travel to patients place of residence
- Must be able to stoop, bend, lift and transfer patients

Duties and Responsibilities:

- Develops, implements and evaluates patients plan of treatment as per agency policies and procedures
- Initiates and sustains the implementation of orders for medications and treatments as prescribed by the Physician in the medical plan of treatment
- Completes, maintains and submits all nursing assessment forms in a timely manner and according to the agency policies and procedures
- Documentation meets professional standards of practice and is in compliance with state regulations
- Documents direct patient care services, coordination, and collaboration with Physicians and other disciplines
- Ensures that documentation is complete and complies with acceptable home health standards and agency policies and procedures

- Observes the patient for changes in condition and reports these changes to the Physician and the Supervising RN/Director of Nursing
- Provides and maintains a safe environment for the patient
- Maintains consistent lines of authority
- Accepts responsibility of an assignment to perform a specialized procedure only when qualified through training, proven competency, clinical background and/or expertise in that area
- Facilitates active and effective communication with team members as demonstrated through case conferences, in-services and timely clinical decisions which provide guidance in the delivery of patient care
- Adhere's to H1PPA guidelines as well as maintains confidentiality of patient information as per agency policies and procedures. Patient concerns are consistently addressed per agency policies and procedures
- Implements Infection control and safety measures as per agency policies and procedures
- Uses equipment and supplies effectively and efficiently
- Provides supervision of Licensed Professional Nurses
- Assumes responsibility for personal growth and development and maintains and upgrades professional knowledge and practice skills through continuing education
- Consults with the Supervising RN and/or the Director of Nursing as issues and concerns arise
- Promotes the agency and its services to the public

I acknowledge that I have read and understand the requirements and responsibilities associated with this job description.

Employee signature _____ Date _____

Supervisor/Coordinator Signature _____ Date _____

CARING HANDS HOME CARE INC
COMPASSIONATE SKILLED SERVICES

To: _____ Date: _____

_____

_____

Subject: Employment Reference Requested for

Social Security # : _____

Dates Employed by Reference: _____ Position:_____

The person named above has applied for a position as a(n) _____with Caring Hands Home Care, Inc. and has listed you as a reference. We place significant value in the screening of our applicants, and would greatly appreciate you completing the information. All information will be held in strict confidence. Thank you for your assistance.

Sincerely,

_____

_____

I hereby authorize Caring Hands Home Care, Inc. to request and also authorize each former employer and person given as a reference to answer all questions that may he asked concerning myself and 'prior work habits. I hereby discharge and release Caring Hands Home Care, lnc. its officers. agents, and employees, from any and all claims, liability, or damage of any kind due to negligence, error. or any other cause whatsoever, which may result in whole or in part from complying with this request.

_____

Applicant

	Excellent	Good	Fair	Poor
Job Knowledge				
Quality				
Quantity				
Attitude				
Dependability				
Punctuality				
Honesty				

Would you employ this person again? Yes ☐ No ☐

Please verify employment dates: From _____ To _____

Comments: _____

_____

_____

Title: _____ Relationship to Applicant: _____

Telephone #: _____

Signature: _____ Date: _____

CARING HANDS HOME CARE INC
COMPASSIONATE SKILLED SERVICES

To: _____ Date: _____

_____

_____

Subject: Employment Reference Requested for

Social Security # : _____

Dates Employed by Reference: _____ Position:_____

The person named above has applied for a position as a(n) _____with Caring Hands Home Care, Inc. and has listed you as a reference. We place significant value in the screening of our applicants, and would greatly appreciate you completing the information. All information will be held in strict confidence. Thank you for your assistance.

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_____

Applicant

	Excellent	Good	Fair	Poor
Job Knowledge				
Quality				
Quantity				
Attitude				
Dependability				
Punctuality				
Honesty				

Would you employ this person again? Yes ☐ No ☐

Please verify employment dates: From _____ To _____

Comments: _____

_____

_____

Title: _____ Relationship to Applicant: _____

Telephone #: _____

Signature: _____ Date: _____

CARING HANDS HOME CARE INC
COMPASSIONATE SKILLED SERVICES

Name: _____

The Following is a list of many of the skills required for effective home health care. It is important that you feel competent in these areas and can demonstrate expertise. The purpose of the checklist is to help identify learning needs, provide the learning expertise necessary to develop competency, and ensure expertise in certain clinical areas.

	PLEASE CHECK ONE		FOR OFFICE USE ONLY	
Responsibility, Skill, or Procedure	**I Feel competent performing**	**I have never done**	**Performance (initial and date)**	**Comments**
Handwashing				
Body mechanics				
Vital signs				
CPR (certification)				
Emergency use of adrenalin				
Assessment of: Cardiopulmonary System				
Respiratory System				
Gastrointestinal System				
Genitourinary System				
Head and Neck				
Neurological System				
Mental Status				
Integumentary System				
Musculoskeletal System				
Care of patient requiring IV therapy				
Inserting IV Catheter				
Inserting Butterfly				
Inserting Heparin Lock				
Oral Hygiene				
General Postoperative Care				
Hemovacs				
Drains (JP's)				
Removing Sutures				
Cleansing Wounds				
Sterile Gloving				
Dry Sterile Dressings				

	PLEASE CHECK ONE		FOR OFFICE USE ONLY	
Responsibility, Skill, or Procedure	**I Feel competent performing**	**I have never done**	**Performance (initial and date)**	**Comments**
Wet to Dry Dressings				
Duoderm				
Stomahesive				
Occlusive Dressings				
Wound Irrigations				
Caring for Patients with Burns				
Caring for Patients with Ostomies:				
• Colostomy Care				
• Colostomy Irrigation				
• Ileostomy Care				
Heal Conduit Care				
Tracheotomy Care				
Reinsertion of Tracheotomy Tubes				
Suctioning: Operating Suction Machine				
Naso-oral Suctioning				
Trach Suctioning				
Providing Percussion and Postural Drainage				
Nebulizer Treatment				
BIPAP				
CPAP				
Caring for Patient on Ventilator				
Intermittent Self Catheterization: Male/Female				
Removal and Insertion of Suprapubic Catheters				
Care or Patient with Suprapubic Catheter				
Bladder Irrigations				
Urinary Catheter Insertion:				
• Indwelling				
• For Sterile Specimen				
• To Check Residual				

CARING HANDS HOME CARE INC
COMPASSIONATE SKILLED SERVICES

	PLEASE CHECK ONE		FOR OFFICE USE ONLY	
Responsibility, Skill, or Procedure	**I Feel competent performing**	**I have never done**	**Performance (initial and date)**	**Comments**
Caring for Patient with Hickman/Brovisc Catheter				
Caring for Implanted Access Ports				
Caring for Implanted Infusion Pumps				
Caring for Ambulatory Infusion Pumps				
Pain Management				
Caring for the Dying Patient				
Caring for the Patient with AIDS				
Morphine Administration via Epidural Catheters				
Patient with Pacemaker				
Assessment and Interventions for Anaphylactic Shock				
Inserting Oral Airway				
Using Ambubag				
Insertion of NG Tube				
Care for NG Tube				
NG Gavage/Feedings				
Insertion of Gastrostomy Tube				
Care of Gastrostomy Tube				
Gastrostomy Feedings				
PPN				
Collecting Specimens:				
Sputum for C & S				
Stool Specimens				
Clean Voided Urine				
Venipunctures for Blood Work				
Wound for C & S				
Throat for C & S				
Cast Care				
Wrapping Ace Bandages				

CARING HANDS HOME CARE INC
COMPASSIONATE SKILLED SERVICES

	PLEASE CHECK ONE		FOR OFFICE USE ONLY	
Responsibility, Skill, or Procedure	**I Feel competent performing**	**I have never done**	**Performance (initial and date)**	**Comments**
Catheter Care				
Enemas:				
• Fleet				
• Soapsuds				
• Tap Water				
Bowel Training				
Administering Rectal Suppositories				
Vaginal Irrigations				
Perineal Care				
Diabetes: Blood Glucose Self-monitoring				
Skin, Foot, and Nail Care				
Urine Checks For S&A				
Insulin Administration				
Medications:				
• Assessing Injection Sites				
• Intramuscular Injections				
• Intradermal Injections				
• Heparin-subcutaneously				
• Ear Drops				
• Eye Drops/Ointment				
• Eye Irrigation				
• Maintaining Heparin Lock				
• Changing IV Fluids				
• Calculating Flow Rate				
• Adding Medication to IV Fluids				
• Administering IV Drip Medications				
• Operating IV Pump				
• Administering IV Push				
• Administering IV Heparin				
• Caring for IV Site				
• Changing IV Tubing				
• Administering IV Narcotics				
• Caring for Patient with Central Venous Catheter				

	PLEASE CHECK ONE		FOR OFFICE USE ONLY	
Responsibility, Skill, or Procedure	**I Feel competent performing**	**I have never done**	**Performance (initial and date)**	**Comments**
ROM-active and passive				
Applying Hot Compresses				
Applying Heating Pad or Hot Water Bottle				
Sitz Baths				
Intake and Output				

Signature: _____

Date: _____

Obtaining Your NPI Number

All of our nurses need to obtain an NPI number. It is similar to a state license number and is free of charge.

This number is used by our billing department.

Please log onto https://nppes.cms.hhs.gov/NPPES/Welcome.do to obtain your number.

After you get your number **please email it to** yourcareeer@chhc1.com.

Please call the office if you have any questions.

Thank you very much.

Regards,

Caring Hands Home Care
Human Resources

CARING HANDS HOME CARE INC
COMPASSIONATE SKILLED SERVICES

Medical History Questionnaire

The object of this form is to avoid assignment that may be injurious to health.

Name: _____ DOB: _____

Social Security #: _____ Position Sought: _____

Personal Physician: _____

	YES	NO	If YES, Explain
Do you need glasses to read?			
Have you ever had nerve trouble?			
Have you ever worked with radioactive material?			
Have you ever had seizures or convulsions?			
Do you wear contact lenses?			
Do you take medicine regularly?			
Have you ever injured your back?			
Have you ever worn a back brace or knee brace?			
Have you ever had a head injury?			
Do you ever use a hearing aid?			
Have you ever had a rupture, wear a truss?			
Have you ever had radiation therapy?			

	YES	NO	If YES, Explain
Been operated on, been advised to have an operation, been a patient in hospital, sanitarium, or institution?			
Been seriously injured?			
Been refused employment for health reasons OR been forced to give up a job because of health?			
Been made ill by your work?			
Received Workmen's Compensation?			
Been rejected for military service for health reasons OR been discharged for health reasons?			
Received a pension for disability?			
Been refused life insurance or driver's license for health reasons?			
Been operated on, been advised to have an operation, been a patient in hospital, sanitarium, or institution?			
Been seriously injured?			
Been refused employment for health reasons OR been forced to give up a job because of health?			
Been made ill by your work?			

	YES	NO	If YES, Explain
Diabetes			
High Blood Pressure			
Tuberculosis			
Nervous Breakdown			
Heart Trouble			
Varicose Veins			
Arthritis			
Epilepsy			
Allergies			
History of habituation or addiction to depressants. stimulants, narcotics, or alcohol.			

The above statements are true to the best of my knowledge. I understand that any misstatement of fact is grounds for release.

Date: _____

Signature: _____

HIV Related Information Confidentiality Statement

Confidential HIV- related information is any information indicating that a person has had any HIV-related test or had HIV infection, HIV-related illness, AIDS, or information that a person has been potentially exposed to HIV_ State law prohibits me from making further disclosure of this information without specific written consent of the person to whom it pertains, as is permitted by law.

Any unauthorized further disclosure of this information is in violation of state law and may result in a fine or jail sentence or both.

This it to certify that I have read and understand the New York State Department of Health Memorandum (Series 90-1) titled "recommendations for the Prevention and Management of Bloodborne Disease Transmission in Home Care Setting" & have been oriented to Confidentiality & Universal Precautions regarding all HIV information.

Employee: _____ Title: _____

Employee Signature: _____ Initials: _____

Date: _____

CARING HANDS HOME CARE INC
COMPASSIONATE SKILLED SERVICES

Pre-Employment Physical

Name of Applicant: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Previous History Please indicate any history of the following:

		YES	NO	Comments *(If you answer **YES**, please explain)*
1	Hypertension (high blood pressure)	☐	☐	
2	Cardiac (heart) disease	☐	☐	
3	Diabetes mellitus	☐	☐	
4	Tuberculosis	☐	☐	
5	Renal (kidney) or bladder disease	☐	☐	
6	Headaches	☐	☐	
7	Epilepsy	☐	☐	
8	Allergies	☐	☐	
9	Emotional Problems	☐	☐	
10	No known history of habituation or addiction to depressants, stimulants, narcotics, or alcohol	☐	☐	

Medical Statement

Immunizations

PPD: Date Insertion: _____ Date Read: _____ Results: _____

	DATE	RESULTS	POSITIVE	NEGATIVE
Rubella Titer			☐	☐
Rubeola Titer			☐	☐
Varicella Titer			☐	☐
Mumps Titer			☐	☐
			☐	☐
			☐	☐

(Ail individuals with negative results must have a skin test once a year.)
Positive findings appropriate clinical follow-up.

Doctor's Signature: _____ Date: _____

CARING HANDS HOME CARE INC
COMPASSIONATE SKILLED SERVICES

ANNUAL TUBERCULOSIS QUESTIONNAIRE

Employee Name: _____

For personnel who have a known positive PPD and previously negative chest x-ray, you are requested to complete this questionnaire with either a YES or NO.

		YES	NO
1	Unexplained Fevers		
2	Night Sweats		
3	Unintentional weight loss		
4	Cough		
5	Hoarseness		
6	Bloody Sputum		
7	Have you completed INH therapy?		
8	Have you ever had a BCG vaccine?		
9	Have you had an x-ray while employed here?		

Employee Signature: _____ Date: _____

Follow-up needed ☐ **YES** ☐ **NO**

Comments:

Agency Representative: _____ Date: _____

Bill of Rights

As a patient of Caring Hands Home Care, you have the right to:

1. Be informed of your rights both verbally and in writing at the time of admission and prior to the initiation of care.
2. Receive competent; individualized care and service from Caring Hands Home Care staff regardless of age, race, color, national origin, religion, sex, disease, disability, or any other category protected by law or decisions regarding advance derivatives.
3. Be treated with dignity, courtesy, consideration, respect, and have your property treated with respect.
4. Be informed verbally and in writing of the services available and related charges, as they apply to the primary insurance, other payers and self- pay coverage before care is initiated. To be informed of any changes in the sources of payment and your responsibility as soon as possible but no later than thirty (30) calendar days after Caring Hands Home Care, becomes aware of the change.
5. Be informed both orally and in writing, in advance of the Plan of Care, and to be included in the planning of care before treatment begins; be informed of all treatment prescribed, when and how services will be provided, and the names and functions of any person affiliated program providing care and services, including photo identification of agency and participate in the development of the discharge plan.
6. Participate in the planning of your care and be advised In advance of any changes in care.
7. Refuse care and treatment after being fully informed of and understanding the consequences of such actions to initiate and Advance Derivative, living Well," durable power of attorney and other derivatives about your care consistent with applicable law and regulations. Refuse to participate in research or experimental treatment.
8. To appropriate assessment of pain and management of his/ her pain.
9. Receive information regarding community resources and to be informed of any financial relationships between Caring Hands Home Care and other providers to which you may be referred to by the agency.
10. Be informed of the procedures for submitting complaints, voice complaints and recommend changes in policies and services to Director of Patient Services by calling the following telephone number (631) 371-9763. The expression of such complaints by the patient or patient designee shall be free from interference, coercion, discrimination or reprisal. If dissatisfied with the outcome, you may also submit the complaint to the New York State Department of Health or any outside representative of the patient's choice.
11. Express any complaints about the care and services provided or not provided and complaints concerning lack of respect for property by personnel furnishing services on behalf of Caring Hands Home Care, and to expect agency to investigate such complaints within 15 days of receipt of complaint. Also, if dissatisfied with outcome, may submit an appeal to the agencies governing authority, which will be reviewed with in 30 days of appeal request.

12. Receive timely notice of impending discharge or transfer to another agency or to a different level of care and to be advised of the consequences and alternatives to such transfers,
13. Privacy, including confidential treatment of records and access to your records on request. Information will not be released without written consent except for. those instances requires by law, regulation or third party reimbursement.
14. In the situation when the patient lacks capacity to exercise these rights, the rights shall be exercised by an individual, guardian or entity legally authorized to represent the patient

Bill of Rights Page 1 of 2

Notice of Privacy Practices

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Get a list of those with whom we've shared Information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any this privacy time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

Our Uses and Disclosures		
How do we typically use or share your health information? We typically use or share your health information in the following ways.		
Treat you	We can use your health information and share it with other professionals who are treating you.	***Example**: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example**: We use health information about you to manage your treatment and services.*

Bill for your services	We can use and share your health information to bill and get payment from health plans or other entities.	***Example**: We give information about you to your health insurance plan, so it will pay for your services.*

Work with a medical examiner or funeral director	We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests	• We can use or share health information about you: ○ For workers' compensation claims ○ For law enforcement purposes or with a law enforcement official ○ With health oversight agencies for activities authorized by law ○ For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We do not create or manage a hospital directory nor do we create or maintain psychotherapy notes. We will never share any substance abuse treatment records, mental health information or HIV/AIDS related information without your written permission.

Individualized Disaster Plan

To all Nursing Staff and Family: In the event of a disaster you are to follow the criteria in our Disaster Plan. Please review and update as needed and if updated please notify the Director of Patient Care Services immediately.

- Utilize your emergency telephone list in the front of the chart
- Your Nursing Supervisor will call you to initiate the Individualized Disaster Plan
- You, the RN/LPN may have to initiate the Disaster Plan so Immediately notify Family, Agency and Nursing Supervisor
- Communication Plans: Should all communication systems fail, the patient is to be transported immediately to the nearest shelter or hospital. Assess each situation as it may be unique. Should the agency telephone system fail, please call the answering service directly at 631 6894120 and go to your emergency telephone list in the chart and call Brigit Durkin RN DPS cell phone number. You should be in close contact with the family at all times during this process.
- Nurse on duty must ensure the following: adequate supplies of food, water, pharmacy, medical equipment, for at least 96 hours. Report to the family and supervisor.
- Keep a log of power outages and notify PSEG Emergency Hotline number. Be mindful of the time without electricity and know the amount of backup time available for all medical equipment requiring electricity i.e. ventilators.
- Listen closely and ongoing to Radio News and /or TV News Stations for the latest ongoing storms and disaster plans. Listen to what the emergency management team is telling you.
- Now is not the time to be a hero, stay calm
- Inform CHHC know if you are affected by an emergency and if you are evacuating to a different location.

Brigit Durkin RN Administrator - 631 371-9763 cell

Identification Badges

Policy:

All active field personnel will wear, in full display, Picture Identification Badges on all assignments regardless of setting.

Purpose:

To ensure proper identification of Caring Hands Home Care employees.

Procedure:

When an applicant is accepted to go through the interview process, he/she will be advised to bring three (3) self-photos (1"x1"). If applicant is considered eligible for hire, self-photos will be distributed in the following manner:

- One photo will be placed in the upper right-hand corner of personnel file.
- One photo will be attached to a temporary Identification Badge and given to the applicant after the interview process is completed. The temporary badge will have an expiration date of one month from date of hire.
- One photo will be attached to an Identification Badge after the full personnel file and the first assignment(s) is made. Caring Hands Home Care will laminate the permanent Identification Badge and return it with the first paycheck to the field personnel.
- The applicant will sign the employment application indicating their acceptance of an Identification Badge.
- There will be a $10.00 charge for any replacement badges.

BLOOD & INFECTIOUS MATERIALS EXPOSURE

POLICY:

Any employee exposed to blood or infectious material shall receive at no cost a confidential medical evaluation and follow-up.

PROCEDURE:

The Agency will follow recommendations of the Health Department.

POST-EXPOSURE EVALUATION & FOLLOW UP

A. Immediately upon occupational exposure, the employee should take steps to possibly minimize the risk of potential transmission of pathogens:

1. For needle sticks or other parenteral contact, the site should be bled. Wash thoroughly with soap and water.
2. For an eye or mucous membrane exposure, rinse with copious amounts of water.
3. For other exposure, wash with soap and water using vigorous friction.

B. The incident shall be reported to the employee's immediate Supervisor. Document route of exposure and circumstances under which exposure occurred and identification of the source individual unless infeasible or prohibited by law.

C. The Agency shall seek permission from the source individual to determine HIV and HBV status through blood testing. If consent is not obtained, the Agency shall document that the legally required consent could not be obtained.

D. Results of the source individual's I-11V and HBV status shall be made available to the employee. The employee will be informed of the laws regarding confidentiality of the infectious status and Identity of the source individual.

E. The exposed employee's blood shall be collected and tested after Consent is obtained and as soon as feasible after the incident. If The employee consents to baseline blood collection, but does not Consent at that time to HIV, serologic testing, the sample shall be Preserved for 90 days. The employee may elect to have baseline Sample tested within 90 days post-exposure.

F. Post-Exposure Prophylaxis, when medically indicated, as Recommended by the US Public Health Service will be provided as well as counseling and evaluation of reported illnesses.

Information Provided to the Healthcare Professional and the Written Opinion

A. The healthcare professional responsible for the evaluation shall be provided with:

1. Route of exposure and circumstances leading to exposure.
2. Description of exposed employees' duties as they relate to the exposure incident.
3. Results of the source individuals blood test if available.
4. All medical records relevant for the appropriate treatment of the employee including HBV vaccination status.

B. The employee shall be provided with a copy of the healthcare Written opinion within 15 days of completion. The written limited to:

1. That the employee has been informed of the results of the evaluation.
2. That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which Require further evaluation or treatment.

C. All other findings or diagnosis shall be confidential and shall not be Included in the written report.

D. Employee records resulting from exposure will be maintained according to the Agency policy.

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
		1	1	

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		1

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):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 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. *(See instructions)*

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				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

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

Signature of Employer or Authorized Representative	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
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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.

Form W-4 (2018)

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

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

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

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

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

General Instructions

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

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

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

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

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

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

Specific Instructions

Personal Allowances Worksheet

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

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

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

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

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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

► Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

OMB No. 1545-0074
2018

1 Your first name and middle initial	Last name	**2 Your social security number**

Home address (number and street or rural route)
1

3 ☐ Single ☐ Married ☐ 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
1 1 1

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. ► ☐

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . .	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2018, and I certify that I meet **both** of the following conditions for exemption. • 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)

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

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

Deductions, Adjustments, and Additional Income Worksheet

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

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

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

Two-Earners/Multiple Jobs Worksheet

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

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

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

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

Instructions for Employer

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

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

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

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

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

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

Personal Allowances Worksheet (Keep for your records.)

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

For accuracy, complete all worksheets that apply.

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

Deductions, Adjustments, and Additional Income Worksheet

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

1	Enter an estimate of your 2018 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income. See Pub. 505 for details	**1**	$
2	Enter: $24,000 if you're married filing jointly or qualifying widow(er); $18,000 if you're head of household; $12,000 if you're single or married filing separately	**2**	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	**3**	$
4	Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	**4**	$
5	**Add** lines 3 and 4 and enter the total	**5**	$
6	Enter an estimate of your 2018 nonwage income (such as dividends or interest)	**6**	$
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	**7**	$
8	**Divide** the amount on line 7 by $4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	**8**	
9	Enter the number from the **Personal Allowances Worksheet,** line H above	**9**	
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	**10**	