Empire Home Care Agency

2637 E Clearfield St. Phila, PA 19134 Phone: (267) -388-6735 Fax: (267) -538-6571

E-mail: empirehomecareagency@gmail.com

EMPIRE HOMECARE AGENCY LLC

EMPLOYEE APPLICATION

Employee's Name: **Date:**

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PERSONNEL FILE AUDIT TOOL

Employee name: _____

Date of Hire: _____

Position: _____

SECTION 1

- EMPLOYMENT APPLICATION
- RESUME
- INTERVIEW REVIEW FORM
- REFERENCES RECORDS (2)
- EMERGENCY CONTACT INFORMATION
- NEW HIRE FORM (STATE SPECIFIC Blank Form Is Provided)

SECTION 2

- LICENSE COPY with VERIFICATION for Professional Staff
- DIPLOMA/DEGREE/TRANSCRIPT OR CERTIFICATE
- SOCIAL SECURITY CARD
- CPR CARD
- DRIVER'S LICENSE
- AUTO INSURANCE (for Field Staff)

SECTION 3

- ORIENTATION CHECKLIST at Hire
- JOB ACCEPTANCE STATEMENT
- JOB DESCRIPTION
- PERFORMANCE EVALUATION (90 DAYS AND YEARLY)
- SKILLS COMPETENCY EVALUATIONS (ON HIRE AND YEARLY)
- TIME SLIP
- COUNSELING/DISCIPLINARY ACTIONS

SECTION 4

- IN-SERVICES REQUIRED ON-HIRE AND THEN YEARLY - INSERT CERTIFICATES AND TESTS
- PROOF OF ALZHEIMER'S TRAINING – SEE SEPARATE FOLDER FOR DETAILS
- OTHER STATE REQUIRED CERTIFICATES
- CEUS

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SECTION 5

- CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION
- FIELD PRACTICES STATEMENT
- CONFIDENTIALITY STATEMENT
- HIPAA CONFIDENTIALITY AGREEMENT
- CORPORATE COMPLIANCE STATEMENT
- POLICIES AND PROCEDURES STATEMENT
- PROTECTIVE EQUIPMENT STATEMENT

SECTION 6

- EMPLOYEE SEPARATION RECORD
- EXIT INTERVIEW
- MISCELLANEOUS

SECTION 7
(In a separate file marked "Confidential")

- HEALTH STATEMENT
- PHYSICAL-FREE OF COMMUNICABLE DISEASE STATEMENT
- TB OR CHEST X-RAY RESULTS
- TB QUESTIONAIRRE ON YEARS BETWEEN CHEST X-RAYS
- HEPATITIS DECLINATION/ACCEPTANCE FORM (EVIDENCE OF HEPATITIS VACCINE COMPLETION IF THE EMPLOYEE MARKS THE FORM THAT THEY HAVE COMPLETED THE SERIES)
- PAYROLL FORMS (W-4 or 1099)
- CRIMINAL HISTORY ATTESTATION
- CRIMINAL HISTORY BACKGROUND RESULTS
- OTHER CONFIDENTIAL INFORMATION

SEPARATE FILE

- ALL I – 9s / ALPHABETIZED IN ONE FOLDER

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	Car Insurance Exp.	Driver's License Exp.	Initial Competency Evaluation	Annual Competency Evaluation	90 Day Performance Evaluation	Annual Performance Evaluation	Professional License Expiration	CPR Exp. Date	Criminal Background check	Misconduct
Compliance Date										
Compliance Date										
Compliance Date										
Compliance Date										
Compliance Date										
Compliance Date										
Compliance Date										
Compliance Date										
Compliance Date										

EMPLOYEE Personnel File

Name_____ Date of Hire _____

Position Held_____

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SECTION 1

- **EMPLOYMENT APPLICATION**
- **RESUME**
- **INTERVIEW REVIEW**
- **REFERENCES CHECKS (Two)**
- **EMERGENCY CONTACT INFORMATION**

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APPLICATION FOR EMPLOYMENT

All prospective employees will receive consideration without discrimination because of race, color, creed, age, natural origin or handicap. All information provided herein will be kept confidential.

PERSONAL

_____ _____

Last Name **First** **Middle** **Date**

_____ _____

Street Address **Home Phone**

_____ _____

City, State, Zip Code **Business Phone**

_____ _____

Emergency contact (person not living with you)_____

Have you ever applied for employment with this Agency? _____Yes _____ No

How many hours a week are you available for work? _____

Are you legally eligible for employment in the United States? _____Yes _____ No

How did you learn of our organization? _ Newspaper Ad __Agency employee ___Other

Are you willing to work: _____Evenings? _____ Weekends?

Position applying for: _____

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EDUCATION:

School Name	Location of School	Course of Study/ Degree	Years	Diploma
College:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Vo-Tech or Trade:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
High School:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Other:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Employment:

List the last five years employment history, starting with the most recent employer.

1. Company Name: _____ Telephone: _____
Address: _____ Dates of Employment: _____
_____ From_____ To _____
_____
City State Zip Code Starting Pay: _____
Job Title and Describe your work: _____ Reason for leaving:_____
_____ _____

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2. Company Name: _____ Telephone: _____
Address: _____ Dates of Employment: _____
_____ From_____ To _____
City State Zip Code Starting Pay: _____
Job Title and Describe your work: _____ Reason for leaving:_____
_____ _____

3. Company Name: _____ Telephone: _____
Address: _____ Dates of Employment: _____
_____ From_____ To _____
_____
City State Zip Code Starting Pay: _____
Job Title and Describe your work: _____ Reason for leaving:_____

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APPLICATION FOR EMPLOYMENT

Was your last name different from your present name during the above listed jobs?
Yes_____ No_____

If yes, what was your name? _____

Are you currently employed? Yes _____ No _____

Do you have reliable transportation? Yes _____No _____

PROFESSIONAL REFERENCES

Persons who can furnish information about job performance

1. Name: _____Telephone:_____
Fax: _____
Address: _____

2. Name: _____Telephone:_____
Fax: _____
Address: _____

3. Name: _____Telephone:_____
Fax: _____
Address: _____

GENERAL

Have you ever been convicted of a crime in the past 5 years, barring employment in a Home Care and community support Agency? Yes _____No _____
Conviction will not necessarily disqualify an applicant from employment.
If yes, describe in full: _____
_____
_____

Are you capable of performing the job set forth in the job description? Yes__No__
If you answered No, which job requirement can you not meet? _____
_____

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APPLICATION FOR EMPLOYMENT

CREDENTIALS/SPECIALIZED SKILLS & QUALIFICATIONS/EQUIPMENT OPERATED

List all states in which licensed giving registration and expiration date. Summarize special job-related skills and qualification acquired from employment or other experience.

_____

_____

_____

_____

_____

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand, that, if employed, falsified statements on this application SHALL BE GROUNDS FOR DISMISSAL.

I Authorize complete investigation of all statements contained herein and herby give my full permission for the Agency to contact and fully discuss my background and history with all persons and entities listed above to give the Agency any and all information concerning my previous employment and any information they may have, and release all former employees and others listed above from all liability for any damage that my result from furnishing the same to the Agency.

I understand and agree that, if hired, my employment is for no definite period arid may, regardless of the date of payment of my wages and salary, be terminated at any time for any lawful reason, without prior notice and with or without cause.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period shall inquire as to whether or not applications are being accepted at that time.

DATE: _____ **SIGNATURE** _____

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INTERVIEW REVIEW

Applicant Name: Date_____

Days and Hours available M Tu W Th F Sa Su

Review:

(Personality):	friendly	average	quiet
(Verbal skills):	excellent	average	poor
(Communicates):	clear	somewhat clear	not very clear
(Flexibility):	very flexible	somewhat	not flexible
(Skill level):	higher skilled	moderately skilled	lower skilled
(Appearance):	professional	semi-professional	not professional

(Good Candidate for employment): yes no

Overall Interview:

_____

_____

_____

_____

_____

_____

_____

_____

Interviewer **Date**

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APPLICANT REFERENCE CHECK (1)

To Whom It May Concern:

The applicant named below has applied for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name: _____ Date of Application: _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

Fax: ( ) _____

I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ Date: _____

To be completed by previous employer:

Date of employment: From: _____ to: _____Position Held: _____

Would you rehire this individual? Yes ___ No _____

Responsibilities:

_____

_____

Reason for Leaving:

_____

_____

Rate of Pay: (weekly/biweekly/salary):

_____+_____

Additional comments (training/skills)

_____

Reference check performed by_____ Date: _____

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APPLICANT REFERENCE CHECK (2)

To Whom It May Concern:

The applicant named below has applied for employment with our firm. Please verify employment and rate the performance of this candidate. This information will not be given to the employee.

To be filled out by applicant:

Applicant Name: _____ Date of Application: _____

Previous Employer: _____ Contact Person: _____

Address: _____ Phone: ( ) _____

Fax: ( ) _____

I hereby authorize the following information to be released for all previous employers listed. I release you and all persons and organizations from all claims and liabilities of any nature from any information given.

Applicant's Signature: _____ Date: _____

To be completed by previous employer:

Date of employment: From: _____ to: _____Position Held: _____

Would you rehire this individual? Yes ___ No ____

Responsibilities:

_____

_____

Reason for Leaving:

_____

_____

Rate of Pay: (weekly/biweekly/salary):

_____+_____

Additional comments (training/skills)

_____

Reference check performed by_____

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Employee Emergency Contact Information

Employee Name: _____

Current Address: _____

Home Phone: _____ Cell Phone: _____

Next of kin: _____ Phone: _____

Relationship: _____ Address: _____

_____

*In case of emergency, please contact:

1. Name: _____ Phone: _____

Relationship: _____ Address: _____

_____

2. Name: _____ Phone: _____

Relationship: _____ Address: _____

_____

***Please notify this Agency immediately if any of the emergency contact information changes.**

Empire Home Care Agency LLC.

2637 E. Clearfield Street Philadelphia, Pa 19134

Office: 267-388-6735 Fax: 267-538-6571

Empirehomecareagency@gmail.com

NEW HIRE FORM

New Hire Information:

First Name:_____ Last Name:_____

Address:_____ City:_____ State:_____

Social Security Number:_____-_____-_____ Date of Birth:_____

Date of Hire_____/_____/_____ Position of Hire:_____

Pay Rate:_____

Bank Name:_____

Routing Number:_____ Account Number:_____

Email Address:_____

Employer's Information:

Business Name: Empire Home Care Agency LLC.

Address: 2637 E. Clearfield Street

City: Philadelphia State: Pennsylvania Zip Code: 19134

(FEIN#): 82-2510744

New Hire (Print Name):_____ Date:_____

New Hire (Signature):_____ Date:_____

Office Use Only

Enrollment Supervisor Signature:_____ Date:_____

Agency Manager Signature:_____ Date:_____

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SECTION 2

- **LICENSE COPY/VERIFICATIONS FOR PROFESSIONAL STAFF –SEE PERSONNEL POLICIES**
- **DIPLOMA/DEGREE TRANSCRIPT**
- **SOCIAL SECURITY CARD**
- **CPR CARD**
- **DRIVER'S LICENSE**
- **AUTO INSURANCE**

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SECTION 3

- **ORIENTATION CHECKLIST AT HIRE**
- **ORIENTATION CHECKLIST WHEN NEW JOB IS ASSUMED**
- **JOB ACCEPTANCE STATEMENT**
  (See Job Description manual)
- **SIGNED JOB DESCRIPTION**
  (See Job Description manual)
- **PERFORMANCE EVALUATION AT 90 DAYS**
  (See Performance Evaluation manual)
- **PERFORMANCE EVALUATION YEARLY**
  (See Performance Evaluation manual)
- **SKILLS COMPETENCY FOR ALL FIELD STAFF AT HIRE**
  (Not required for office staff insert proper form from Competency Evaluation folder)
- **SKILLS COMPETENCY FOR ALL FIELD STAFF ANNUALLY**
  (Not required for office staff insert proper form from Competency Evaluation folder)
- **TIME SLIP (OPTIONAL)**
- **COUNSELING/DISCIPLINARY ACTIONS**
- **CORPORATE COMPLIANCE STATEMENT**

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ORIENTATION PROGRAM			
	INITIALS		**INITIALS**
Agency Mission, Vision and Plan and Organizational Chart		Advance Directives	
Types of Care Provided by the Agency including Information Provided to consumers Regarding Charges		Policies and Procedures HIPAA TB	
Personnel Policies, Job Descriptions and Professional Boundaries of All Disciplines; completion of in-services required at orientation		Training Specific to Job Descriptions and mandatory in-services	
Cultural diversity		Consumer Rights and Grievance Policy	
Ethics, Conflict of Interest and Confidentiality of Consumer Information		Supervision and Evaluation	
Home Safety (including Bathroom, Electrical, Environment, Fire and Hazards)		Safety Issues in the Home (Including Security and Guns in the Home)	
Emergency Preparedness Plan/Actions to Take in the Event of a Disaster		Actions to Take in Unsafe Situations	
OSHA Requirements, Safety and Infection Control in the Home/Standard Precautions		Consumer Care Responsibilities Including Charges for Service/Care	
Incidences and Occurrences reporting		Understanding and coping with Alzheimer's Disease and Dementia	
Identifying and Reporting Abuse, Neglect and Exploitation		Fraud/Abuse/Corporate Compliance, False Claims, False Statements, Whistle Blowing	
Community Resources		Quality Assurance	
Documentation - Record keeping		Photo ID Badge Issued	
Medical Device/Hazards reporting		Exposure Control Plan	

PRINT NAME	**TITLE**
EMPLOYEE SIGNATURE	**DATE**
PRINT NAME	**TITLE**
EMPLOYER SIGNATURE/INITIALS	**DATE**

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ORIENTATION CHECKLIST FOR CURRENT EMPLOYEES ASSIGNED TO A NEW JOB CLASSIFICATION	
	INITIALS
1. Review of all Agency policies and procedures related to new job duties.	
2. Review of Federal, and state regulations.	
3. Review confidentiality of consumer information.	
4. Review contracts for all programs, agencies and individuals related to new job duties.	
5. Review employee benefits.	
6. Review infection control, safety and disaster programs	
7. Consult with and observes other staff in the same job classification regarding consumer job issues.	
8. Review implementation of consumer goals and objectives.	
9. Ensuring safe and effective services to consumers and families.	
10. Establishing and maintaining effective lines of communication.	
11. Practicing staff development including orientation, in-service education and continuing education.	
12. Following job description in performance of duties.	
13. Implementing and evaluating consumer care services related to new job.	
14. Participating in selected in-service programs related to new job.	
15. Encouraging staff participation in problem solving.	
16. Performing other duties as assigned by the Administrator.	

PRINT NAME	**TITLE**
EMPLOYEE SIGNATURE	**DATE**
PRINT NAME	**TITLE**
EMPLOYER SIGNATURE/INITIALS	**DATE**

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TITLE OF POSITION: DIRECT CARE WORKER

TITLE OF IMMEDIATE SUPERVISOR: SUPERVISOR/AGENCY MANAGER
RISK OF EXPOSURE TO BLOODBORNE PATHOGENS – HIGH

POSITION RESPONSIBILITIES
Follows the plan of care to help the consumer to maintain good personal hygiene and maintain a healthful, safe environment, is to perform ONLY those functions specified for each individual consumer.
Receives written instructions from the supervisor.
Knowledge of Agency policies and procedures.
Is oriented and trained in all aspects of care to be provided to consumers.
Ability to demonstrate competency in all areas of training for a direct care worker.
Direct Care Workers may assist consumers with the following activities: a. Self-administration of Medications for consumers who are competent to direct the care b. Housekeeping c. Personal care including grooming and dressing d. Eating and meal preparation e. Oral hygiene and denture care f. Toileting and toilet hygiene g. IADL assistance h. Administering emergency first aid i. Providing or arranging for social interaction j. Providing transportation
Documents observations and services in the individual consumer record.
Reports any change in the consumer's mental or physical condition or in the home situation to his/her immediate supervisor or Agency Manager.
JOB CONDITIONS
The ability to drive and the ability to access consumers' homes which may not be routinely wheelchair accessible are required.
Hearing, eyesight and physical dexterity must be sufficient to perform a physical assessment of the consumer's condition and to perform consumer care/services.
On occasion, may be required to bend, stoop, reach and move consumer weight up to 250 pounds; lift and/or carry up to 30 pounds.
Must be able to communicate clearly, both verbally and in writing in English.
EQUIPMENT OPERATION
Use of BP cuff, thermometer and stethoscope Hand washing materials.
COMPANY INFORMATION
Has access to all consumer medical records which may be discussed with the Supervisor.
QUALIFICATIONS

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Completion of at least the ninth grade. Preferably a high school diploma or equivalent.
Completed one of the following: 1.Obtained a valid nurses license in PA; or 2. Demonstrated competency by passing a competency exam developed by the home care agency which meets PA state regulation; or 3. Completed one of the following: a. A training program developed by a home care agency, home care registry, or other entity which meets the requirements of PA regulation for training. b. A home health aide training program meeting the requirements of 42 CFR 484.36 (relating to the conditions of participation; home health aide services). c. The nurse aide certification and training program sponsored by the PA Department of Education and located at www.pde.state.pa.us. d. A training program meeting the training standards imposed on the agency or registry by virtue of the agency's or registry's participation as a provider in a Medicaid Waiver or other publicly funded program providing home and Community based services to qualifying consumers. e. Another program identified by the Department by subsequent publication in the *Pennsylvania Bulletin* or on the Department's web site.
2. Must be free from health problems that may be injurious to consumer, self and co-workers and must present appropriate evidence to substantiate per agency policy.
3. Must comprehends the basics of personal care, housekeeping and meal preparation and successfully complete the competencies.
4. Must understand and respect consumer's including ethics and confidentiality of care.
5. Must have a criminal check and other checks as required by PA regulation.
6. Must have current CPR certification and First Aide.
ACKNOWLEDGMENT
Employee Name:
Employee Signature: **Date:**

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JOB ACCEPTANCE STATEMENT

I have read, understand and agree to the terms specified in this job description for the position I presently hold. A copy of this job description has been given to me.

I further understand that this job description may be reviewed at any time and that I will be provided with a revised copy.

Employee Signature _____

Date_____

Witness Signature: _____

Date_____

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INSERT APPROPRIATE PERFORMANCE EVALUATION FROM PERFORMANCE EVALUATION MANUAL

Performance Evaluations are to be prepared for each employee at 90 days after hire and then annually.

They must be signed by the employee and the evaluator and they must include goal setting.

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SKILL COMPETENCY

OBSERVATION

EVALUATIONS

INSERT THE APPROPRIATE COMPETENCY EVALUATION AT HIRE, BEFORE A STAFF MEMBER CAN VISIT A CONSUMER, AND THEN ANNUALLY

Note these are not required for office employees

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(To be used at Agency's Option)

TIME SLIPS

Day _____Date: _____ ☐ 1st-15th ☐ 16th - 31st

Employee Name	Title	Time In	Lunch Out	Lunch In	Time Out	Total Hours	Overtime

Visit Notes	Consumer Name	Consumer Number	Code	Time In	Time Out	Comments

Codes

S= SOC	NB = Non-Billable
E = Eval	M= Meeting Team
RV = Revisit	O = Orientation
DC = Discharge	ROC = Resumption
SUP = Supervisory	RC = Recert

*ALL OVERTIME MUST BE APPROVED BY MANAGER AHEAD OF TIME

Employee Signature: _____

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Manager Signature _____

Certify that hours worked are correct for the date listed above
Reviewed By _____ Date: _____

EMPLOYEE COUNSELING REPORT

Employee: _____

Date: _____ / _____ / _____

Job Classification: _____

Reason for Conference/Report:
Commendation
Work Performance
Infraction of Policy
Other (Specify): _____

Type of Communication:
Telephone
Office Conference
Field Conference

Events leading to conference session: _____

_____

_____

_____

Handling of event/session: _____

_____

_____

_____

Recommendation to Employee: _____

_____

_____

_____

Employee Comments: _____

_____

_____

_____

Signature of Employee _____

Date: _____ / _____ / _____

Signature of Counselor_____

Date: _____ / _____ / _____

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COMPLIANCE STATEMENT

The Corporate Compliance Statement provided below is to be acknowledged and signed by every Agency employee as well as every employee working for the Agency on a contract basis.

CORPORATE COMPLIANCE POLICY
Acknowledgment of Receipt and Understanding.
As you know, our Home Care Agency and our Staff members have always been committed to providing exceptional health care and upholding ethical conduct standards and legal compliance.
Our policy formally and clearly states that there is a zero tolerance to any form of fraud or misconduct. This Agency believes that every employee or agent plays a key and active role in maintaining its image and reputation.
I hereby acknowledge that I have apprised of and agree to comply with the Agency's Corporate Compliance Policy. I understand that in no way does this create an obligation or contract of employment and that I, as well as the Agency, have the right to end the employment relationship at any time.
Employee's printed name:
Employee's signature and date:

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SECTION 4

- ## IN-SERVICE TEST AND CERTIFICATES

Required:

Office Staff, at time of initial orientation: **Infection Control, HIPAA –**

All Field Staff, at time of initial orientation: **Infection Control, HIPAA, Bloodborne Pathogens, Medical Device Reporting, TB- Respiratory Disorders**

Individuals Performing Personal Care Duties, at time of initial orientation: **HIPAA, Bloodborne Pathogens, Medical Device Reporting, TB- Respiratory Disorders.**
Within one year: Three other in-services

Individuals (including CNAs) Performing Home Health Aide Duties, at time of initial orientation: **HIPAA, Bloodborne Pathogens, Medical Device Reporting, TB- Respiratory Disorders.**
Within one year: Seven other in-services

- ## OTHER TRAINING CERTIFICATES

- ## CEUS

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EMPLOYEE IN-SERVICE LOG

DATE	EMPLOYEE NAME	SIGNATURE	IN-SERVICE

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SECTION 5

- **CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION (PHI)**
- **FIELD PRACTICES STATEMENT**
- **CONFIDENTIALITY STATEMENT**
- **HIPAA CONFIDENTIALITY AGREEMENT**
- **CORPORATE COMPLIANCE STATEMENT**
- **POLICIES AND PROCEDURES STATEMENT**
- **PROTECTIVE EQUIPMENT STATEMENT (PPE)**

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CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

It is the employer's and the employee's responsibility to ensure that every consumer's health information is always protected. By signing below, you are indicating the acknowledgement of HIPAA and understand that a thorough orientation of the agency's policy regarding consumer's Protected Health Information will be provided to you upon hire.
I understand that I may be handling Protected Health Information. I further understand that there are specific guidelines associated for use and disclosure of Protected Health Information. The agency has sanctions and fines for all individuals failing to comply with HIPAA Rule and Regulations. I agree to protect all Electronic Medical Records including passwords as outlined in the HIPAA policy.

Employee: _____ Date: _____

PROTECTION OF HEALTH INFORMATION

There are specific guidelines to ensure consumer's Protected Health Information is kept private. I understand that my employment with the agency involves handling Protected Health Information. I will ensure consumer's records are protected by enforcing the following measures:

- Consumer Protected Health Information will be transported in a protected travel chart when traveling.
- When transmitting and receiving a fax involving Protected Health Information, I will ensure that it is conducted in a private area.
- Consumer Protected Health Information will be returned to the agency upon acknowledgement of the consumer being discharged.

I always pledge to make every effort to keep consumer's Protected Health Information protected.

Employee: _____ Date: _____

Empire Home Care Agency LLC

2637 E Clearfield St., PA 19134 Phone: (267) -388-6735 Fax: (267) -538-6571

E-mail:empirehomecareagency@gmail.com

REQUIRED HIPAA CONFIDENTIALY AGREEMENT

EMPLOYEE CONFIDENTIALITY AGREEMENT of CONSUMER HEALTH INFORMATION AND

PERSONAL INFORMATION in accordance with HIPAA REGULATIONS

For good consideration and as an inducement for

_____(employer) to employ

_____(employee), the undersigned Employee hereby agrees not to directly or indirectly use, manipulate or copy compete any Protected Health Information (PHI), to include personal health information or personal contact information (address, phone, email address, etc.) with the business of the Agency and its successors and assigns during the period of employment. Misuse of PHI or personal contact information will result in termination and report with action to HIPAA federal agencies. Fines related to civil and criminal offences for gross misconduct with the above information are the direct responsibility of said employee.

The Employee acknowledges that the Agency shall or may in reliance of this agreement provide Employee access to trade secrets, customers and other confidential data and good will. Employee agrees to retain said information as confidential and not to use said information on his or her own behalf or disclose same to any third party or for their own personal or monetary gain.

The Employee agrees to not copy and to return all such Agency supplied Information immediately upon termination of employment. Further employee agrees not to solicit any of the customers or employees of employer for any purpose for a period of two years after termination.

This agreement shall be binding upon and inure to the benefit of the parties, their successors, assigns, and personal representatives.

Signed this _____ day of _____ 20____

_____

Agency

Empire Home Care Agency LLC

2637 E Clearfield St., PA 19134 Phone: (267) -388-6735 Fax: (267) -538-6571

E-mail:empirehomecareagency@gmail.com

FIELD EMPLOYEE STANDARDS AND PROCEDURES

This Agency requires adherence to the following Standards and Procedures:

1. All employees are expected to dress in a manner appropriate to the health care environment, or as directed by the consumer's family. This includes personal hygiene, jewelry, hair and makeup.
2. **Please do not smoke in the presence of a consumer.**
3. Always wear your ID Badge.
4. You are expected to arrive on time to all assignment that you have accepted. However, if an emergency or any situation should cause you to be five minutes late, or more or to be totally absent from the assignment you must notify the Agency immediately. PLEASE DO NOT CALL YOUR CONSUMER DIRECTLY. You may call the Agency 24 hours a day if you need to cancel or reschedule your assignment. **A NO-CALL, NO-SHOW IS GROUNDS FOR TERMINATION!**
5. If you have any problem, incident or accident on the job, do not discuss it with the consumer, but call the Agency immediately.
6. If the consumer asks you to stay longer than your assignment or to leave earlier, you must call the Agency first, for approval.
7. Paraprofessional personnel (i.e. Aides) hereby acknowledge that they **WILL NOT, UNDER ANY CONDITIONS, DISPENSE OR ADMINISTER ANY MEDICATION.**
8. UNDER NO CIRCUMSTANCES are you to ask for or accept any money from your consumer or take-home property that belongs to the consumer.
9. There shall not be any involvement with the consumer's financial affairs (i.e. check writing).
10. You are expected to honor the confidentiality of any consumer information which is obtained in the regular course of your employment.
11. No personal telephone calls should be made or received by you while on assignment.
12. Please do not discuss your pay or any other personal affairs with the consumer family.
13. As an employee of this Agency, you are not authorized to accept any direct employment that may be offered to you by your consumer family. If you are requested to do so, please have the consumer contact us.
14. **It is imperative that all signed notes and documentation including Daily Log, be filled out properly and returned to the office as per our schedule**. If the consumer is unable to sign your note, a family member or responsible party may sign.
15. During employment, this Agency's proprietary materials (i.e. forms, medical records) will be used only in connection with employment and will not be disclosed to anyone without authorization from the Agency.

Employee Signature_____ Date_____

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CONFIDENTIALITY AND NON-COMPETITION AGREEMENT

The Agency requires that the Employee avoid disclosure of confidential information to anyone outside of the Agency and refrain from engaging in unfair competition.

The Employee agrees to refrain from prohibited competition with the Agency and to maintain the confidentiality of information regarding employees, consumers and the Agency business.

The Employee will have access to information not generally made available to the public, such as identity of consumers, pricing, computer-related programs, etc. The Agency prohibits the utilization of this information for any purposes other than for the Agency's own benefit and prohibits disclosure or unauthorized use during employment or at any time thereafter of any confidential information pertaining to Agency administration and/or projects, or outside investigations of the Agency. The employee is prohibited from disclosing any defaming information regarding Agency personnel and/or personnel incidents related to any violations of the personnel policies.

During the course of employment and for a twelve month period thereafter the Employee is prohibited from engaging in any of the following: induce any employee of the Agency to resign, encourage any consumer or entity to discontinue any relationship with the Agency, solicit any consumer of the Agency (current and within the past twelve month period), enter into competitive employment or seek to provide competitive services while employed within twenty-five miles of any office of the Agency, or solicit referrals or opportunities from any referral source.

Upon termination of employment or at the request of the Agency, the Employee is required to return all the Agency's property including keys, consumer records, forms, manual, beeper, etc. to the Agency and will not retain copies.

Violation of this agreement will result in termination and any additional remedy available to the Agency including legal action to remedy all damages including loss of profits, cost of replacing and training employees improperly solicited for competitive employment, etc. suffered by the Agency. Employee will be required to reimburse the Agency for all legal fees, costs and other expenses.

This agreement is in effect during the Employee's employment and for twelve months thereafter. It does not modify the right of the Employee to resign at any time or of the Agency to terminate employment without prior cause, notice or liability and does not modify any other Agency policy.

_____ _____

Employee Date

Empire Home Care Agency LLC

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EMPLOYEE POLICIES AND PROCEDURES

I understand that copies of policy and procedure manuals are available and that it is my responsibility to read, understand and conform to all applicable Agency policies including personnel policies. It is also my responsibility to comply with periodic changes and revisions.

I have read the Agency's Policy and Procedure on Abuse, Neglect and Exploitation and agree to Comply with and am bound by the Policy.

I understand that information contained in any Agency manual does not constitute a contractual relationship between the Agency and its employees, nor is it an expression of my term of employment.

I affirm that I have auto insurance coverage as required by this state and the Agency and I agree to keep it fully in force on any vehicle I use for the conduction of Agency business during the term of my employment. The Agency has the right to request proof of insurance at any time during the term of employment and that I am required to follow all Agency requirements and state and local laws.

I understand that only the Agency has the authority to admit consumers and will supervise with appropriate personnel all services provided.

As a caregiver, I will carry out the plan of treatment, submit time sheets, clinical and progress notes as appropriate and, at a minimum, on a weekly basis, I will participate in developing and reviewing plans of care, periodic consumer evaluations and care conferences, discharge planning and schedule coordination. I will provide services within the geographic area covered by the Agency. I will attend required staff meeting and inservice training. Home health aides are required to have 12 hours of inservice training annually.

I understand that I must remit documentation of services performed prior to payment for those services and that payroll procedures require timely and accurate completion of documentation that must be submitted prior to payment for services provided. I understand that all information, both written and verbal, regarding consumer and employee health conditions is strictly confidential and protected under federal and state law. The presence of a communicable or venereal disease; testing, results or known infection by HIV, Hepatitis, Tuberculosis; information concerning child abuse, mental health, drug or alcohol abuse is protected under specific law. All information in connection with the examination, care or provision of services to any consumer will not be disclosed without the individual's written consent except as may be necessary to provide services as required by law. Information may be used in statistical or other summary form or for clinical purposes only if the identity of the individual is not disclosed. I understand the violation of consumer/ employee confidentiality is subject to civil and criminal penalties.
If I mistakenly exceed my accrued or earned sick or vacation leave balance, I authorize the Agency to deduct any amount from my paycheck(s) to correct my accrued or earned sick or vacation leave balance. I understand that this company does not routinely perform drug testing on its employees but may do so at its discretion. I understand that this company is an "At Will" organization and may hire and fire at will. **Employee Signature**_____ **Date**_____

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PERSONAL PROTECTIVE EQUIPMENT FOR SAFETY AND INFECTION CONTROL ACKNOWLEDGMENT

I understand a Personal Protective Equipment (PPE Kit) is available in the office and contains the following:

- **Barrier Safety Goggles**
- **CPR Shield Face Barrier**
- **Fluid Resistant Gown**
- **Gloves**
- **Biohazard Bag**
- **Sharps Container**
- **3M Respirator Mask (N95 or similar purchased from Uline.com)**

I have been instructed in the use of this equipment and understand that I must comply with Policies and Procedures regarding use of personal protective equipment.

Signature/Title_____ **Date**_____

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Compliance Statement

The Corporate Compliance Statement provided below is to be acknowledged and signed by every Agency employee as well as every employee working for the Agency on a contractual basis.

CORPORATE COMPLIANCE POLICY
Acknowledgment of Receipt and Understanding
As you know, our Agency and our Staff members have always been committed to providing exceptional health care and upholding ethical conduct standards and legal compliance.
Our policy formally and clearly states that there is a zero tolerance to any form of fraud or misconduct. This Agency believes that every employee or agent plays a key and active role in maintaining its image and reputation.
I hereby acknowledge that I have apprised of and agree to comply with the Agency's Corporate Compliance Policy. I understand that in no way does this create an obligation or contract of employment and that I, as well as the Agency, have the right to end the employment relationship at any time.
Employee's printed name:
Employee's signature: Date:

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SECTION 6

- **EMPLOYEE SEPARATION RECORD**
- **EXIT INTERVIEW**
- **MISCELLANEOUS**

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EMPLOYEE SEPARATION RECORD
Employee Name:
Social Security Number:
Date of Hire:
Last day of work:
Reason for separation:
Is this employee eligible for rehire?
[ ] YES
Comments
Supervisor:
Date:

Empire Home Care Agency LLC

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EXIT INTERVIEW	
YOUR COMMENTS ARE IMPORTANT TO US. PLEASE COMPLETE THE QUESTIONS ON THIS FORM. YOUR ANSWERS WILL BE USED TO DEVELOP RECOMMENDATIONS FOR IMPROVEMENT. PLEASE BE CANDID WITH US.	
NAME:	TITLE:
DATE OF HIRE:	DATE OF RESIGNATION:
1. MOST IMPORTANT REASON FOR LEAVING:	
2. WAS THE INFORMATION GIVEN TO YOU ABOUT HOURS, SALARY, AND JOB DUTIES AN ACCURATE REFLECTION OF WHAT YOU FOUND ON THE JOB?	
3. WERE YOU ADEQUATELY PREPARED TO PERFORM YOUR JOB? IF NOT, WHAT COULD HAVE BEEN DONE TO HELP YOU PERFORM MORE EFFECTIVELY?	
4. WHAT DID YOU LIKE BEST ABOUT WORKING FOR THE AGENCY?	
5. WHAT DID YOU LIKE LEAST ABOUT WORKING FOR THE AGENCY?	
6. DID YOU RECEIVE SUFFICIENT INFORMATION ABOUT YOUR PERFORMANCE?	

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SECTION 7

(Separate employee file marked '*confidential*')

- **HEALTH STATEMENT**
- **PHYSICIAN HEALTH STATEMENT**
  'FREE OF COMMUNICABLES'
- **IMMUNIZATIONS**
- **TB QUESTIONAIRE**
- **PAYROLL FORMS**
- **CRIMINAL HISTORY ATTESTATION**
- **CRIMINAL HISTORY CHECK RESULTS**
- **OTHER CONFIDENTIAL INFORMATION**

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HEALTH STATEMENT

Applicant Name: _____Date_____

I, _____ hereby attest that the state of my health is such that it will enable me to perform the duties of a health care professional. I further specifically attest that I am free of any and all potentially contagious diseases including, but not limited to those listed below:

AIDS	Anthrax	Chickenpox	Cholera
Diphtheria	Encephalitis	Hepatitis, Types A, B and C	Influenza
Leprosy (Hansen's Disease)	Leptospirosis	Malaria	Measles (Rubeola)
Meningitis	Mononucleosis	Mumps	Whooping Cough
Plague	Poliomyelitis	Psittacosis (Ornithosis)	Rabies
Rocky Mountain Spotted Fever	Rubella (German Measles)	Shigellosis	Smallpox
Tetanus	Tularemia	Tuberculosis	Typhoid Fever

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HEPATITIS VACCINE REQUIREMENT

I _____ acknowledge that I am at risk of exposure or have been unknowingly exposed to Hepatitis B as a result of my employment and acknowledge that the Agency will arrange for me to receive the Hepatitis vaccine at no cost to myself. It is my decision to:

- ☐ Request that I receive the Hepatitis vaccine.
- ☐ Refuse the Hepatitis vaccine and HOLD HARMLESS THE AGENCY. I understand that by declining the vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccine series at no charge to me.
- ☐ Provide written proof of immunity (attach)
- ☐ Provide written proof of previous vaccination (attach)
- ☐ Provide written proof of medical contraindication (attach)

Signature: _____ Date: _____

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TB TARGETED MEDICAL QUESTIONNAIRE FORM

To be completed by employee:

_____
Print Name

		YES	NO
1.	Have you ever had a positive TB skin test or history of TB infection? If the answer is YES, please answering the following:	____	____
2.	Have you ever had the BCG vaccine?	____	____
3.	Do you have prolonged or recurrent fever?	____	____
4.	Have you recently lost weight?	____	____
5.	Do you have a chronic cough?	____	____
6.	Do you cough up blood?	____	____
7.	Do you have sweating at night?	____	____

8. Do you have any of the following risk factors which may substantially? Increase the risk of tuberculosis?

____ a. Silicosis (Lung Disease)

____ b. Gastrectomy

____ c. Intestinal Bypass

____ d. Weight 10% or more below ideal body weight?

____ e. Chronic Renal Disease

____ f. Diabetes Mellitus

____ g. Prolonged high-dose corticosteroid therapy or other Immunosuppressive therapy

____ h. Hematologic Disorder i.e. leukemia or lymphoma

____ i. Exposure to HIV or AIDS

____ j. Other malignancies

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TB TARGETED MEDICAL QUESTIONNAIRE FORM

Employee Signature _____ Date _____

Empire Home Care Agency LLC

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E-mail:empirehomecareagency@gmail.com

SEPARATE FILE

ALL I – 9s

ALPHABETIZED IN ONE FOLDER

Empire Home Care Agency LLC.
2637 E. Clearfield Street, Philadelphia, Pa 19134
Office :267-388-6735 Fax: 267-538-6571
Email: empirehomecareagency@gmail.com
Website: www.empirehomecareagency.com

Receiving of MEMOS & Training

I, _____ have received the following Memos:

- Timesheets Memo
- Consumer/Client Hospital Admittance Memo
- Mandatory Online Training due within 45 days

_____ _____

Employee Signature Date

_____ _____

Hector Martinez (Office Administrators) Date

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CHILDLINE AND ABUSE REGISTRY
P.O. BOX 8170
HARRISBURG, PENNSYLVANIA 17105-8170

CONSENT/RELEASE OF INFORMATION AUTHORIZATION FORM FOR THE PENNSYLVANIA CHILD ABUSE HISTORY CERTIFICATION

I, (_____), hereby authorize the PA Department of Human Sevices, ChildLine to
Applicant's Name

release my Pennsylvania Child Abuse History Clearance information directly to (Empire Home Care Agency LLC.).
Name of Requesting Agency

I understand that this information is confidential in nature pursuant to §6339 (relating to information in confidential reports) of the Child Protective Services Law (CPSL) (23 Pa.C.S Chapter 63) and is not otherwise to be released by (Empire Home Care Agency LLC.) without my expressed authorization or pursuant to Section 3490.126 of
Name of Requesting Agency

Title 55 of the Pennsylvania Code which states this information is confidential and the requesting agency can be held criminally liable for a breach of confidentiality related to release of this information. **I also understand that the aforementioned information will not be released directly to me (_____) as stated**
Applicant's Name

on the Pennsylvania Child Abuse History Certification application. I understand that I will not receive a copy of my Pennsylvania Child Abuse History Certification directly from ChildLine; however, I may request a copy of my Pennsylvania Child Abuse History Certification from (Empire Home Care Agency LLC.) upon written request.
Name of Requesting Agency

I have read this Consent/Release of Information Authorization form and fully understand and agree to its content. I further understand and agree to all information and ramifications of the Pennsylvania Child Abuse History Certification application as it otherwise relates to this consent. Further I understand that if I am listed in the statewide database for child abuse that my consent allows the result stating such information to be shared with the agency/organization noted on next page.

Please send my certification result(s) to:

Agency Name: Empire Home Care Agency LLc.

Agency Street Address: 2637 E. Clearfield Street

Agency City, State, Zip Code: Philadelphia, PA 19134

Date

Applicant's Signature

As the agency/organization representative, I understand that, except for the subject of a report, persons who receive this information are subject to the confidentiality provisions of the CPSL and 55 Pa. Code, Chapter 3490 and are required to ensure the confidentiality and security of the information and are liable for civil and criminal penalties for releasing information to persons who are not permitted access to this information. I agree to receive and maintain this information in accordance with these requirements.

Date

Agency's Representative Signature

NOTE: IF THE PENNSYLVANIA CHILD ABUSE HISTORY CERTIFICATION FORM/APPLICATION (CY 113) IS NOT COMPLETED ACCURATELY OR IF IT IS INCOMPLETE, THE CY 113 WILL BE RETURNED TO THE APPLICANT AND NOT BACK TO A THIRD PARTY.

Revised 12-29-15

PENNSYLVANIA CHILD ABUSE HISTORY CERTIFICATION

Type or print clearly in ink. If obtaining this certification for non-volunteer purposes or if, as a volunteer having direct volunteer contact with children, you have obtained a certification free of charge within the previous 57 months, enclose an $13.00 money order or check payable to the PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES or a payment authorization code provided by your organization. **DO NOT send cash.**

Certifications for the purpose of "volunteer having direct volunteer contact with children" may be obtained free of charge once every 57 months.

Send to CHILDLINE AND ABUSE REGISTRY, PA DEPARTMENT OF HUMAN SERVICES, P.O. BOX 8170 HARRISBURG, PA 17105-8170.

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

PURPOSE OF CERTIFICATION (Check one box only)

- ☐ Foster parent
- ☐ Prospective adoptive parent
- ☐ Employee of child care services
- ☐ School employee governed by the Public School Code
- ☐ School employee not governed by the Public School Code
- ☐ Self-employed provider of child-care services in a family child-care home
- ☐ An individual 14 years of age or older applying for or holding a paid position as an employee with a program, activity, or service
- ☐ An individual seeking to provide child-care services under contract with a child care facility or program
- ☐ An individual 18 years or older who resides in the home of a foster parent for children for at least 30 days in a calendar year
- ☐ An individual 18 years or older who resides in the home of a certified or licensed child-care provider for at least 30 days in a calendar year
- ☐ Volunteer having direct volunteer contact with children

  If purpose is volunteer having direct volunteer contact with children, choose SUB PURPOSE:
  - ☐ Big Brother/Big Sister and/or affiliate
  - ☐ Domestic violence shelter and/or affiliate
  - ☐ Rape crisis center and/or affiliate
  - ☐ Other: _____
- ☐ PA Department of Human Services Employment & Training Program participant (signature required below)

SIGNATURE OF OIM/CAO REPRESENTATIVE _____ OIM/CAO PHONE NUMBER _____

- ☐ An individual 18 years or older, excluding individuals receiving services, who resides in a family living home, community home for individuals with an intellectual disability, or host home for children for at least 30 days in a calendar year
- ☐ An individual 18 years or older who resides in the home of a prospective adoptive parent for at least 30 days in a calendar year

AGENCY/ORGANIZATION NAME:	PAYMENT AUTHORIZATION CODE, IF APPLICABLE:
Empire Home Care Agency LLC.	

☒ Consent/Release of Information Authorization form is attached. Applicant must fill in the "Other Address" sections. By completing the other address sections, you are agreeing that the organization will have access to the status and outcome of your certification application.

APPLICANT DEMOGRAPHIC INFORMATION (DO NOT USE INITIALS)

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX
SOCIAL SECURITY NUMBER	**GENDER**	**DATE OF BIRTH (MM/DD/YYYY)**	**AGE**
— —	☐ Male ☐ Female ☐ Not reported		

Disclosure of your Social Security number is voluntary. It is sought under 23 Pa.C.S. §§ 6336(a)(1) (relating to information in statewide database), 6344 (relating to employees having contact with children; adoptive and foster parents), 6344.1 (relating to information relating to certified or licensed child-care home residents), and 6344.2 (relating to volunteers having contact with children). The department will use your Social Security number to search the statewide database to determine whether you are listed as the perpetrator in an indicated or founded report of child abuse.

HOME ADDRESS	MAILING ADDRESS (if different from home address)	OTHER ADDRESS (if Consent/Release of Information Authorization form is attached)
ADDRESS LINE 1	ADDRESS LINE 1	ADDRESS LINE 1 2637 E. Clearfield Street
ADDRESS LINE 2	ADDRESS LINE 2	ADDRESS LINE 2
CITY	CITY	CITY Philadelphia
COUNTY	COUNTY	COUNTY Philadelphia
STATE/REGION/PROVINCE	STATE/REGION/PROVINCE	STATE/REGION/PROVINCE PA
ZIP/POSTAL CODE	ZIP/POSTAL CODE	ZIP/POSTAL CODE 19134
COUNTRY	COUNTRY	COUNTRY
☐ Different mailing address	ATTENTION	ATTENTION Empire Home Care Agency LLC.

CONTACT INFORMATION

HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	MOBILE TELEPHONE NUMBER

EMAIL (By submitting an email contact, you are agreeing to ChildLine contacting you at this address.)

PENNSYLVANIA CHILD ABUSE HISTORY CERTIFICATION

PREVIOUS NAMES USED SINCE 1975 (Include maiden name, nickname and aliases.)			
First	Middle	Last	Suffix
1.			
2.			
3.			
4.			
5.			

PREVIOUS ADDRESSES SINCE 1975 (Please list all addresses since 1975, partial address acceptable; attach additional pages if necessary.)
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

HOUSEHOLD MEMBERS (Please list everyone who lived with you at any time since 1975 to present. Please include parent, guardian or the person(s) who raised you; attach additional pages as necessary.)			
Name (First, Middle, Last)	Relationship	Present Age	Gender
1.	☐ Parent ☐ Guardian ☐ person(s) who raised you		
2.	☐ Parent ☐ Guardian ☐ person(s) who raised you		
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

I affirm that the above information is accurate and complete to the best of my knowledge and belief and submitted as true and correct under penalty of law (Section 4904 of the Pennsylvania Crimes Code). If I selected volunteer, I understand that I can only use the certificate for volunteer purposes.

APPLICANT'S SIGNATURE

DATE

CHILDLINE USE ONLY		
DATE RECEIVED BY CHILDLINE	SUFFICIENT PAYMENT INFORMATION RECEIVED ☐ YES ☐ NO ☐ VALID PAYMENT AUTHORIZATION CODE ☐ WAIVED (supervisor initials)_____	CERTIFICATION ID #

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►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):

☐ 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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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
		Empire Home Care Agency LLC.

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
2637 E. Clearfield Street	Philadelphia	PA	19134

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ▶ ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

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

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

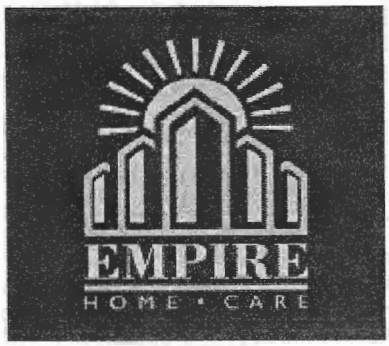
Step 5: Sign Here

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

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

Employers Only

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



Name:_____ Date:_____

Have you been living in the State of Pennsylvania for the last 2 years: ____Yes ____No

If No, _____ Years_____
City and State

List of Addresses you lived at in the last 2 years:

Address	City	State

State ID Issue State: _____

State ID Number:_____

State ID Issue Date:_____ Expiration Date:_____

Employees (Print Name):_____

Employee Signature:_____

Staff:_____ Date:_____