General Hire Checklist

Personnel records are considered confidential. Files are kept in locked drawers in the HR file cabinet and documents are kept current. The documents listed in the checklist below must be completed, signed, and placed in the employee personnel record for it to be considered complete and in compliance with Agency Policy.

✓	Document	Notes
☐	Application for Employment	
☐	Reference Verification	
☐	Abuse Policy / Report Resource	
☐	Drug-Free Workplace Program	
☐	Notification of Incidents / Refusal of Services	
☐	Confidentiality & Conflict of Interest	
☐	Passport Ethical Standard	
☐	HIPAA Agreement, Notice & Receipt Acknowledgement	
☐	Client / Patient Bill of Rights	
☐	Code of Ethics	
☐	Insurance Waiver	
☐	Hepatitis B Vaccine Consent / Decline	
☐	I-9 Form	
☐	W-4 Form	
☐	Performance Appraisal Evaluation (within 1 year of hire)	
☐	Employee Orientation Checklist	
☐	Acknowledgment of Employee Orientation	
☐	Job Offer Letter	

Employee Name ____________ **Date** ____________

H/R Coordinator ____________ **Hire Date** ____________

Employment Application

Personal Information

Full Name		**Date**	
Address		**Apt/Suite**	
City		**State / Zip**	
Email		**Phone**	
SSN		**Date of Birth**	

Emergency Contact

Name ______ Relationship ______ Phone ______

How were you referred to us?

☐ Family/Friend ☐ Employee ☐ Internet ☐ Other: ______

Job Interests

Date available for work ______ **Anticipated wage** ______

Position applied for ______

Please check the specialty area(s) that best match your experience and education

☐ Homecare ☐ Medical/Surgical ☐ IV Therapy ☐ Intermittent Care
☐ Residential Care ☐ Hospice ☐ Rehabilitation ☐ Pediatrics / Maternal Child
☐ Supplemental Staffing ☐ Nursing Home ☐ Hospital ☐ Geriatric
☐ Psychiatric

Availability

Work Status	Shifts Available	Days Available
☐ Full Time (avg 32+ hrs/wk) ☐ Part Time (under 32 hrs/wk) ☐ PRN / As-needed	☐ 7am – 3pm ☐ 3pm – 11pm ☐ 11pm – 7am ☐ Visits only	☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Employment Eligibility

Are you legally authorized to work in the U.S.? ○ Yes ○ No

Have you ever been employed by Havens Corner Home Health Care before? ◯ Yes ◯ No

If yes, start and end dates:

Have you ever been convicted of a felony? ◯ Yes ◯ No

If yes, please explain:

Work History

Employer 1

Company / Individual | **Phone**

Address

Job Title | **Wage** | ☐ Hour ☐ Salary

Responsibilities

From | **To**

Supervisor | **Phone**

Reason for Leaving

Employer 2

Company / Individual | **Phone**

Address

Job Title | **Wage** | ☐ Hour ☐ Salary

Responsibilities

From | **To**

Supervisor | **Phone**

Reason for Leaving

Employer 3

Company / Individual | **Phone**

Address

Job Title | **Wage** | ☐ Hour ☐ Salary

Responsibilities

From | **To**

Supervisor | **Phone**

Reason for Leaving

Education

High School		**City / State**	
Year Graduated			
College		**City / State**	
Year Graduated		**Degree**	

Licenses / Certifications

#	License or Certification	ID Number	Expiration	State
1				
2				
3				

I attest that the above information is true and accurate to the best of my knowledge. I further authorize Havens Corner Home Health Care to contact any previous employer or reference for information regarding my character, employment history, or work ethics.

Employee Signature		**Date**	
Print Name			

Reference Form

Date

Mail to | **Manager Phone**

Address

Applicant Name | **SSN**

Position Held | **Dates of Employment**

Assessment of Work Ethic

Category	Excellent	Good	Poor
Quality of Work	○	○	○
Reliability	○	○	○
Conduct & Performance	○	○	○
Ability to Work with Others	○	○	○
Eligible for Rehire	○	○	○

If you answered "Poor" or "No" to rehire, or have other information — positive or negative — about the applicant's ability, character, or integrity, please describe below:

I hereby authorize any person, company, or organization to furnish Havens Corner Home Health Care with answers to questions regarding my employment record, and release all liability arising from this inquiry.

Applicant Signature | **Date**

Print Name

Reference Check Completed by | **Date**

☐ **Telephone Inquiry** Spoke with:

☐ **Mailing** Date Mailed:

Abuse Policy

Patients of Havens Corner Home Health Care are our most valuable resource and, therefore, their health and safety is of serious concern. They will always be treated with dignity and respect. Mistreatment in the form of verbal or physical abuse of any nature will not be tolerated. Any employee guilty of abusing a patient is subject to immediate termination. Local authorities will be notified immediately, and criminal charges may be filed.

Employee Signature		**Date**	
Print Name			
Agency Representative		**Date**	

Abuse Report Resources

For Adults:

Franklin County Office on Aging — 280 East Broad Street, Room 300, Columbus, OH 43215-4527
Senior Options: (614) 462-6200 • Adult Protective Services: (614) 462-4348
Administration: (614) 462-5230 • Fax: (614) 462-5300 • Ohio Relay TDD: (800) 750-0750

For Children:

If you suspect a child is being abused or neglected, call the Franklin County Children Services 24-Hour Child Abuse Hotline at **(614) 229-7000**.

Drug-Free Workplace Program

In accordance with our Drug-Free Workplace (HR Policy) and federal and state law, all employees, as a condition of employment, must:

• Abide by the terms of the Drug-Free Workplace program.

• Notify the employer of any criminal drug-statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction.

Within thirty (30) days of receiving notice of an employee's conviction, the agency will impose remedial measures up to and including termination.

Employee Acknowledgement of Receipt and Understanding

Employee Signature		Date	
Print Name			

Notification of Incidents / Refusal of Services

If your client is admitted to the hospital, taken to the emergency room, goes on vacation, has an accident, has a change of address, or refuses services, you must notify Havens Corner Home Health Care immediately. Failure to follow this policy will lead to **disciplinary action and grounds for termination**.

Falsifying or submitting timesheets for services not rendered while a client is in the hospital, on vacation, in a nursing home, or in a rehab facility will subject you to legal action by the State of Ohio Department of Health, Ohio Department of Job and Family Services, the Office of the Attorney General, and the Office of the Inspector General.

Employee Signature		Date	
Print Name			

Confidentiality & Conflict of Interest

I understand and agree to refrain from unauthorized disclosure or use of confidential information from Havens Corner Home Health Care. This includes any information concerning clients, other employees, or agency operations. I recognize that the unauthorized release of confidential information may subject me to civil action under federal and/or state law and may result in termination of employment.

I acknowledge, by means of this statement, that I am not involved in any transaction, investment, or other legal or personal relationship in which I would profit directly or indirectly as a result of my position as

____________________ with Havens Corner Home Health Care.

I agree to disclose to Havens Corner Home Health Care any actual, apparent, or potential conflicts of interest that may arise. I agree to abide by determinations made by Agency Management and to hold harmless and indemnify Havens Corner Home Health Care for any damages or costs associated with the defense of any claim arising from any conflict of interest created knowingly or unwittingly on my part.

Employee Signature ____________________ **Date** __________

Print Name ____________________

Witness Signature ____________________ **Date** __________

PASSPORT Employee Code of Ethics

Ethical, Professional, Respectful, and Legal Service Standards as defined in OAC 173-39-02 — ODA Provider certification requirements (effective 4/16/22). The provider shall not engage in any unethical, unprofessional, disrespectful, or illegal behavior including the following:

1. Consuming alcohol while providing services.
2. Consuming medicine, drugs, or other chemical substances illegally, unprescribed, or in a way that impairs the provider.
3. Accepting, obtaining, or attempting to obtain money, gifts, or tips from the individual or family.
4. Engaging the individual in sexual conduct or conduct a reasonable person would interpret as sexual.
5. Leaving the individual's home while scheduled for service without notifying the agency supervisor or emergency contact.
6. Treating ODA or its designee disrespectfully.
7. Engaging in distractions while providing service: TV/movies/games on personal devices; non-care socialization; care for another person; smoking; sleeping; bringing children, friends, pets; discussing religion, politics, or personal issues.
8. Behavior that causes (or may cause) physical, verbal, mental, or emotional distress to the individual, including posting photos on social media without consent.
9. Inappropriate involvement in the individual's personal relationships.
10. Making decisions, or being designated to make decisions, for the individual (POA, guardianship, etc.).
11. Selling to or purchasing from the individual.
12. Consuming the individual's food or drink, or using personal property without consent.
13. Taking the individual to the provider's business site (unless permitted).
14. Conflict of interest or manipulation of services for personal gain that harms the individual.

Employee Signature		**Date**	
Print Name			

HIPAA Confidentiality & Non-Disclosure Agreement

Our agency's information systems contain confidential records pertaining to our business operations, clients, business associates, health-care professionals, and employees. In accordance with HIPAA regulations and agency policy, you have the responsibility to protect such data. **You Agree:**

1. To respect the privacy and confidentiality of information accessed through any system or record.
2. To refrain from discussing patient information where it could be overheard, or with anyone not permitted access.
3. To disclose confidential patient, business, financial, or employee information only to those authorized to receive it.
4. To safeguard and not disclose passwords or user IDs; you are responsible for all actions recorded under your credentials.
5. Not to attempt to learn or use another employee's password or user ID.
6. To immediately report any suspected compromise of your password or user ID to the HIPAA Compliance Officer.
7. Not to release the contents of any patient or agency record except to fulfill your work assignment.
8. Not to remove or copy any protected information or reports from their storage location except to fulfill your work assignment.
9. Not to sell, loan, alter, or destroy any protected information except as properly authorized.
10. Not to leave a workstation unattended without logging off or securing materials.
11. Not to access or request any protected information unnecessary to your job function.
12. Not to permit others to use your credentials to access the agency's systems.
13. To permit your access to the agency's information system to be monitored.
14. Not to download or copy unlicensed software or applications.
15. Not to access pornographic, illegal, or otherwise inappropriate material on agency systems.
16. Not to use agency systems to send harassing, defamatory, obscene, or threatening messages.
17. To report any suspected or known unauthorized access, use, or disclosure of protected information.
18. To abide by agency HIPAA policies and procedures, including those governing personal use of systems on breaks.

I further understand that the duties set forth in this document continue after the termination, expiration, or cancellation of this agreement, including after my employment ends. I also understand my credentials may be revoked if I fail to abide by these rules.

Employee Signature ____________ **Date** ____________

Print Name ____________

Agency Representative ____________ **Date** ____________

Client / Patient Bill of Rights

- Receive appropriate care without discrimination in accordance with physician orders.
- Be informed of any financial benefits when referred to an organization.
- Be fully informed of one's responsibilities.
- Receive information about the scope of services that the organization will provide and the specific limitations on those services.
- Be informed of patient rights regarding the collection and reporting of OASIS information, including the right to refuse to answer specific questions and the right to review and request changes to the OASIS assessment.
- Be informed of patient rights under state law to formulate advance directives.
- Be fully informed, in advance, about service/care including the disciplines that furnish care, the frequency of visits, and any modifications to the plan of care.
- Receive information about services covered under the Medicare home-health or hospice benefits.
- Participate in the development and periodic revision of the plan of care.
- Refuse care or treatment after the consequences are fully presented.
- Be informed, orally and in writing, of charges and any payments expected from third parties and the patient.
- Have one's property and person treated with respect, consideration, and dignity.
- Have family or guardian exercise rights when the patient is judged incompetent.
- Identify visiting staff through proper identification.
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source and misappropriation of property.
- Voice grievances regarding treatment or care, or recommend changes in policy, staff, or service, without restraint, interference, coercion, discrimination, or reprisal.
- Have grievances investigated.
- Choose a health-care provider, including an attending physician.
- Confidentiality and privacy of all information contained in the patient record and of Protected Health Information.
- Be advised of agency policies and procedures regarding the disclosure of clinical records.

Employee Signature		**Date**	
Print Name			

Code of Ethics — All Staff

1. Introduce yourself as Miss, Ms., Mrs., or Mr. Address adult members in the same manner.
2. When answering the telephone say, "This is the [Family] residence, [Name], home-care aide speaking."
3. Do not give clients or families your personal address or telephone number. If asked, say that this is not permitted.
4. Do not discuss personal problems, religious or political matters with the family.
5. NEVER take the client or the client's family away from the home (e.g., shopping or clinic visits) without prior consent from your supervisor.
6. You are responsible for your own belongings on the job; avoid carrying large sums of money.
7. Do not accept money, clothing, or any other gifts.
8. Removal of client property or belongings is unlawful.
9. Do not sell anything to a client or solicit a sale.
10. Do not make loans to the client or family. Report any such requests to your supervisor.
11. Do not make personal telephone calls to or from the home.
12. Do not make calls or visits to a family after hours. Never give your phone number to a client or family.
13. Never accept keys to a client's home. If this creates a problem, contact your supervisor.
14. You may take your own lunch and beverages. If asked to eat with the client, decline politely.
15. Do not bring friends or relatives to the client's home.
16. Do not consume alcohol or use medications/drugs for any non-medical purpose in the client's home or prior to service delivery.
17. Do not smoke in the client's home, with or without permission.
18. Do not use the client's car.
19. No changes in hours or duties are to be made by the employee. Family or client requests must be directed to the office.
20. Report important happenings/changes to your supervisor — no one home, change of address, in-home incident (complete an incident report), family illness, unexpected hospitalization, etc.
21. Plan to leave early so you can be on time. If you may be late, call the office with a valid reason.
22. Confidentiality — do not discuss the client or family with anyone outside the agency.
23. Inform your supervisor of unusual behavior or conditions (food/clothing shortage, severe disagreements, pests, behavior issues, lack of cooperation, requests outside the plan of care, etc.).
24. If illness makes it impossible to work, telephone the office immediately so we can restaff the shift.
25. Be friendly, pleasant, and interested in the client and family — but do not become personal.
26. Do not give the client any medication or treatment unless instructed by the RN. Home-health aides cannot administer medications.
27. Call the supervisor when in doubt about what to do in any situation.
28. Do not give the client any medical advice — refer them to their attending physician.
29. Any minor incident (e.g., a fall without injury, skin tear) must be reported immediately.
30. Learn how the family and client like things — follow the instructions you have received.
31. If instructions are not working out, talk it over with your supervisor.
32. If you have an accident on the job or become ill and cannot work, call your supervisor.

33. Remember: you are a representative of our agency. People judge the whole agency by the employee.

34. All clients remain under supervision of a registered nurse who makes supervisory visits per agency policy. An RN is always available by phone.

I have had an opportunity to ask questions regarding the above. I have read the instructions, understand them, and agree to abide by these rules.

Employee Signature		**Date**	
Print Name			

Insurance Waiver

I, ______________________, waive all rights to transport any clients or people related to Havens Corner Home Health Care until I can provide a current copy of automobile insurance.

I understand that all responsibility and consequences will be upon me if I act against this rule. I give up all rights to sue or hold Havens Corner Home Health Care responsible for any damages or injuries.

Employee Signature ______________________ **Date** __________

Print Name ______________________

Administrative Signature ______________________ **Date** __________

Hepatitis B Vaccine Consent / Declination

All eligible (Hepatitis B at-risk) employees must complete **ONE** section of this form, indicating whether they accept the vaccine, decline it, or have prior vaccination records.

Hepatitis B Vaccine Consent

I do wish to receive the Hepatitis B Virus (HBV) vaccine. I have read the attached information memorandum and understand it thoroughly.

Print Name		**SSN**	
Signature		**Date**	

Hepatitis B Vaccine Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring HBV infection. I have been given the opportunity to be vaccinated; I decline at this time. If I later wish to be vaccinated, I can receive the series at no charge.

Print Name		**SSN**	
Signature		**Date**	

Prior Vaccination or Immunity

I have completed the series of Hepatitis B vaccine (attach record of dates) or have attached documentation of prior immunity, and do not wish to receive the vaccine at this time.

Print Name		**SSN**	
Signature		**Date**	

Federal Forms — I-9 and W-4

The next pages contain the current official Form I-9 (Employment Eligibility Verification, U.S. Citizenship and Immigration Services) and Form W-4 (Employee's Withholding Certificate, Internal Revenue Service). Complete both forms in any modern PDF reader. They are fillable and will be saved with the rest of this packet.

Form I-9 — Sections 1 and 2 are required. Section 1 must be completed by the end of your first day of work; Section 2 will be completed with your H/R Coordinator using your acceptable identification documents (see List A / B / C in the form).

Form W-4 — Complete Steps 1 and 5 at minimum. Steps 2 – 4 are optional and apply only if you have multiple jobs, dependents, or other adjustments.

☐ Form I-9 completed ☐ Form W-4 completed

Employee Signature		**Date**	
Print Name			

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. An alien authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preaparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card **2.** Permanent Resident Card or Alien Registration Receipt Card (Form I-551) **3.** Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa **4.** Employment Authorization Document that contains a photograph (Form I-766) **5.** For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. **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		**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, sex, height, eye color, and address **2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address **3.** School ID card with a photograph **4.** Voter's registration card **5.** U.S. Military card or draft record **6.** Military dependent's ID card **7.** U.S. Coast Guard Merchant Mariner Card **8.** Native American tribal document **9.** Driver's license issued by a Canadian government authority **For persons under age 18 who are unable to present a document listed above:** **10.** School record or report card **11.** Clinic, doctor, or hospital record **12.** Day-care or nursery school record		**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.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) **3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal **4.** Native American tribal document **5.** U.S. Citizen ID Card (Form I-197) **6.** Identification Card for Use of Resident Citizen in the United States (Form I-179) **7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

List A	OR	List B		List C
• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with “RE” notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.		Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A,
Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B, Reverification and Rehire (formerly Section 3)

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

USCIS Form I-9 Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

Check here if you used an alternative procedure authorized by DHS to examine documents.

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

2026

Step 1: Enter Personal Information

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

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

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . **3** $

Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

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

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

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

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

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

2. Expect to work only part of the year;

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

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

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

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

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

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

Specific Instructions

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

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

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

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

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

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

Step 4.

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . **1** $ ______

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . **2a** $ ______

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b . . . . **2b** $ ______

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . **2c** $ ______

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . . . **3** ______

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (plus any other additional amount you want withheld) . . . . **4** $ ______

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1	Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.		
a	**Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000	**1a**	$
b	**Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation	**1b**	$
c	**Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000	**1c**	$
2	Add lines 1a, 1b, and 1c. Enter the result here	**2**	$
3	**Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):		
a	Enter $6,000 if you are age 65 or older before the end of the year	**3a**	$
b	Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment	**3b**	$
4	Add lines 3a and 3b. Enter the result here	**4**	$
5	Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information	**5**	$
6	**Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:		
a	**Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income	**6a**	$
b	**State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately)	**6b**	$
c	**Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums)	**6c**	$
d	**Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income	**6d**	$
e	**Other itemized deductions.** Enter the amount for other itemized deductions	**6e**	$
7	Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here	**7**	$
8	**Limitation on itemized deductions.**		
a	Enter your total income	**8a**	$
b	Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9	**8b**	$
9	Enter: • $768,700 if you're married filing jointly or a qualifying surviving spouse • $640,600 if you're single or head of household • $384,350 if you're married filing separately	**9**	$
10	If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here	**10**	$
11	**Standard deduction.** Enter: • $32,200 if you're married filing jointly or a qualifying surviving spouse • $24,150 if you're head of household • $16,100 if you're single or married filing separately	**11**	$
12	**Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly)	**12**	$
13	Add lines 11 and 12. Enter the result here	**13**	$
14	If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12	**14**	$
15	Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4	**15**	$

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$480	$850	$850	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$90	$850	$1,020	$1,020	$1,020	$1,070	$1,870	$1,870	$1,870	$1,870	$1,870	$1,970
$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$280	$850	$950	$1,020	$1,020	$1,020	$1,020	$1,560	$1,870	$1,870	$1,870
$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

Employee Orientation Checklist

Employee ______________________ **Position** ______________________

#	Orientation To	Yes	N/A	Initials / Date
1	Basic Home Safety: bathroom, electrical, environmental, fire	☐	☐	
2	Safety Program — risks within agency and patient home; actions to eliminate, minimize, or report; incident reporting; reporting common problems and user errors	☐	☐	
3	Storage / handling / access to / transport of supplies, medical gases, drugs	☐	☐	
4	ID / handling / disposal of infectious wastes (blood & body fluids / Precautions)	☐	☐	
5	ID / handling / disposal of hazardous waste (cytotoxic / chemotherapy drugs)	☐	☐	
6	Infection Control & Prevention — PPE & hand washing; aseptic procedures; communicable infections (TB, AIDS, etc.); cleaning/disinfecting reusable equipment; Standard Precautions	☐	☐	
7	Confidentiality of patient information / HIPAA policies and practices	☐	☐	
8	Community resources	☐	☐	
9	Policies / procedures	☐	☐	
10	Responsibilities related to safety and infection control	☐	☐	
11	Advance Directives policies / procedures	☐	☐	
12	Specific job duties / responsibilities, limitations, and performance standards	☐	☐	
13	Screening for alleged or suspected abuse/neglect — reporting	☐	☐	
14	Emergency operations plan & role	☐	☐	
15	Equipment use / management relevant to job description	☐	☐	
16	Tuberculosis Program / Plan (OSHA)	☐	☐	
17	Hazardous Materials in the Workplace program (MSDS, OSHA)	☐	☐	
18	Bloodborne Pathogen Program (OSHA)	☐	☐	
19	Managing the environment of care (patient & agency site) — safety, fire, security on home visits, utilities, emergencies	☐	☐	
20	Patient rights & responsibilities	☐	☐	
21	Agency complaint mechanism / Medicare state hotline # and purpose	☐	☐	
22	Performance Improvement program & role	☐	☐	
23	On-call & answering service	☐	☐	
24	Ethical aspects of care, treatment, and services; addressing ethical issues	☐	☐	
25	Philosophy / mission / purpose / vision / goals	☐	☐	
26	Interpreters / communicating with hearing-, speech-, visually-impaired	☐	☐	
27	Sentinel event policy / process	☐	☐	
28	Physical safety (body mechanics, safe lifting)	☐	☐	

#	Orientation To	Yes	N/A	Initials / Date
29	Cultural diversity & sensitivity	☐	☐	
30	Role of the health team	☐	☐	
31	Family / State Medical Leave Act	☐	☐	
32	Organizational structure, line of authority & responsibility, supervision process	☐	☐	
33	Hours of work; benefits	☐	☐	
34	Documentation requirements	☐	☐	
35	Medical Device Reporting Act	☐	☐	
36	Equal Employment Opportunity Act	☐	☐	
37	Sexual Harassment Act	☐	☐	
38	Salary / hourly wage reimbursement	☐	☐	
39	Unemployment and Worker's Compensation	☐	☐	
40	Malpractice coverage	☐	☐	
41	Assessing and managing pain	☐	☐	

Other: ____________________

Employee Signature ____________________ **Date** __________

Print Name ____________________

Supervisor Signature ____________________ **Date** __________

Acknowledgment of Orientation — All Staff

Please put your initials on **EACH** line.

Initials	Statement
	I have received information concerning organizational structure, agency mission statement, and services offered.
	I have received my job description and understand my relationship with other agency personnel.
	I have received and reviewed the Employee Handbook and will perform according to the guidelines outlined.
	I know where to find the Policy & Procedure manual and the procedure for retrieval and review.
	I understand my legal, ethical, and moral obligation to maintain confidentiality of patient and agency information.
	I acknowledge that the agency maintains a drug-free workplace.

Acknowledgment of Orientation — Clinical Staff

Initials	Statement
	I understand that the agency is governed by state and federal regulations and that I must perform according to these requirements.
	I understand the difference between a legal requirement and an ethical consideration.
	I am aware that maintaining a comfortable, safe environment for all patients is one of my primary responsibilities.
	I understand the definition of an unusual occurrence and will report any to my supervisor immediately (incident reporting).
	I have reviewed a copy of the "Patient Bill of Rights" and understand my responsibility to the guidelines outlined.
	I understand Advance Directives and "Do Not Resuscitate" orders, and how these affect the care I give.
	I have reviewed the policy regarding safety & disaster preparedness and the employee / client grievance procedures.
	I have reviewed and understand the significance of: criminal background check; sex-offender registry; OSHA's Bloodborne Pathogens Standards and the Patient Abuse Policy.
	I understand how to complete the Daily Report, time sheets, document all patient/client visits, and access medical supplies.

Employee Signature ____________________ **Date** __________

Print Name ____________________

Agency Representative ____________________ **Date** __________