

**ACCLAIM HOMECARE | ACCLAIM PROFESSIONAL HEALTHCARE**

4340 Redwood Highway, A14

San Rafael CA 94903

**Employment Application**

FULL NAME: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SSN: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

## EDUCATION:

\_\_\_\_\_ HS DIPLOMA OR EQUIVALENT

\_\_\_\_\_ C.N.A / EXPIRATION: \_\_\_\_\_

\_\_\_\_\_ UNDERGRADUATE DEGREE

\_\_\_\_\_ C.N.A / EXPIRATION: \_\_\_\_\_

\_\_\_\_\_ ACUTE CARE

OTHER: \_\_\_\_\_

DRIVING? \_\_\_\_\_ YES \_\_\_\_\_ NO+

WITH CAR? \_\_\_\_\_ YES \_\_\_\_\_ NO

**WORK HISTORY (Start with most recent)**

PREVIOUS EMPLOYER (1): \_\_\_\_\_

DATES OF EMPLOYMENT: \_\_\_\_\_ TITLE/ JOB DESCRIPTION: \_\_\_\_\_

DUTIES: \_\_\_\_\_

SUPERVISOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

Can we contact this employer? \_\_\_\_\_ Yes \_\_\_\_\_ No

PREVIOUS EMPLOYER (2): \_\_\_\_\_

DATES OF EMPLOYMENT: \_\_\_\_\_ TITLE/ JOB DESCRIPTION: \_\_\_\_\_

DUTIES: \_\_\_\_\_

SUPERVISOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

Can we contact this employer? \_\_\_\_\_ Yes \_\_\_\_\_ No

PREVIOUS EMPLOYER (3): \_\_\_\_\_

DATES OF EMPLOYMENT: \_\_\_\_\_ TITLE/ JOB DESCRIPTION: \_\_\_\_\_

DUTIES: \_\_\_\_\_

SUPERVISOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

Can we contact this employer? \_\_\_\_\_ Yes \_\_\_\_\_ No

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**PROFESSIONAL REFERENCES (PLEASE PROVIDE THREE WORK REFERENCES)**

NAME: \_\_\_\_\_  
COMPANY: \_\_\_\_\_  
NAME: \_\_\_\_\_  
COMPANY: \_\_\_\_\_  
NAME: \_\_\_\_\_  
COMPANY: \_\_\_\_\_

PHONE: \_\_\_\_\_  
JOB TITLE: \_\_\_\_\_  
JOB TITLE: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
JOB TITLE: \_\_\_\_\_  
PHONE: \_\_\_\_\_

**SKILLS/ EXPERIENCE**

_____ Hoyer Lift	_____ Wheelchair	_____ Catheter	_____ Gait Belt
_____ Walker	_____ Hospital Bed	_____ Colostomy	_____ Chair Lift
_____ Alzheimer's	_____ Dementia	_____ Parkinson's	_____ Stroke
_____ Quadriplegic	_____ Sundowner's	_____ Hospice	

Pet Allergies: \_\_\_\_\_

Smoking: \_\_\_\_\_

Non-smoking: \_\_\_\_\_

**AVAILABILITY**

\_\_\_\_\_ Hourly    \_\_\_\_\_ Live-In

	AM	PM	EVENING
<b>Monday</b>	_____	_____	_____
<b>Tuesday</b>	_____	_____	_____
<b>Wednesday</b>	_____	_____	_____
<b>Thursday</b>	_____	_____	_____
<b>Friday</b>	_____	_____	_____
<b>Saturday</b>	_____	_____	_____
<b>Sunday</b>	_____	_____	_____

**AUTHORIZATION**

I, \_\_\_\_\_ (please print name) hereby authorize Acclaim Homecare/Acclaim Professional Healthcare to perform a check of my references and background check on my criminal history, driving record and credit report for employment purposes.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

PERSONNEL RECORD

(Form to be completed by employee)

DATE

NAME OF FACILITY

FACILITY ADDRESS

FACILITY FILE NUMBER

1. PERSONAL

NAME (LASTFIRSTMIDDLE)

TELEPHONE

ADDRESS

ARE YOU 18 YEARS OF AGE OR OLDER?  
☐ YES ☐ NO IF NO, PLEASE STATE YOUR AGE

SOCIAL SECURITY NUMBER: (VOLUNTARY FOR ID ONLY)

DATE OF LAST PHYSICAL EXAMINATION

DATE OF LAST TB TEST

HAVE YOU EVER BEEN EMPLOYED UNDER A DIFFERENT NAME? ☐ YES ☐ NO IF YES, PLEASE LIST ALL NAMES USED.

DO YOU POSSESS A VALID CALIFORNIA DRIVER'S LICENSE? ☐ YES ☐ NO

HAS YOUR DRIVER'S LICENSE EVER BEEN SUSPENDED OR REVOKED? ☐ YES ☐ NO

CDL NUMBER

IF YES, PLEASE EXPLAIN ON BACK OF FORM.

NEAREST LIVING RELATIVE — NAME:

TELEPHONE NUMBER

RELATIONSHIP

ADDRESS

2. POSITION

TITLE

SALARY

HOURS

DATE OF EMPLOYMENT

NAME OF SUPERVISOR

3. PREVIOUS EMPLOYMENT (List most recent experience first. If additional space is needed, please attach a separate page.)

NAME AND ADDRESS OF EMPLOYER	TELEPHONE NUMBER	JOB TITLE AND TYPE OF WORK	REASON FOR LEAVING	DATES	
				FROM	TO

4. EDUCATION

CIRCLE HIGHEST YEAR COMPLETED

DIPLOMA

CURRENTLY ENROLLED IN HIGH SCHOOL COMPLETION COURSE?

6 7 8 9 10 11 12

☐ NO ☐ YES IF YES, GIVE EXPECTED COMPLETION DATE

EMPLOYMENT — RELATED EDUCATION COURSES

COURSE TITLE	NAME OF SCHOOL OR ORGANIZATION AND ADDRESS	NUMBER UNITS COMPLETED	DATE COMPLETED	CURRENTLY ENROLLED

**4. EDUCATION (Continued)**

NAME UNIVERSITY, COLLEGE OR BUSINESS SCHOOL AND ADDRESS	MAJOR SUBJECT	NO. OF YEARS COMPLETED	NO. OF UNITS COMPLETED	DIPLOMA DEGREE OR CERTIFICATE	DATE COMPLETED

**5. REFERENCES**

List names of three persons who can give information about your background, character, abilities, etc.

NAME	ADDRESS	TELEPHONE NUMBER	RELATIONSHIP TO YOU (FRIEND, EMPLOYER, ETC.)

**6. PROFESSIONAL AND TECHNICAL QUALIFICATIONS**

A. List Licenses or Certificates of Competence held:

B. Names of Professional Associations of which you are a member:

NOTES:

*I hereby certify under penalty of perjury that the above statements are true and correct. I give my permission for any necessary verification.*

SIGNATURE OF EMPLOYEE

DATE

# CRIMINAL RECORD STATEMENT

*State law requires that persons associated with licensed facilities or Home Care Aide Registry applicants be fingerprinted and disclose any conviction. A conviction is any plea of guilty or nolo contendere (no contest) or a verdict of guilty. The fingerprints will be used to obtain a copy of any criminal history you may have.*

**Have you ever been convicted of a crime in California ? . . . . .** ☐ **YES** ☐ **NO**

*You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.*

**Have you ever been convicted of a crime from another state, federal court, military or jurisdiction outside of U.S.? . . . . .** ☐ **YES** ☐ **NO**

Criminal convictions from another State or Federal court are considered the same as criminal convictions in California.

If you answer YES, give details on the back of this page indicating the nature and circumstances of each crime and the date and the location in which each crime occurred.

You must disclose convictions, including reckless and drunk driving convictions even if:

1. It happened a long time ago;
2. It was only a misdemeanor;
3. You didn't have to go to court (your attorney went for you);
4. You had no jail time or the sentence was only a fine or probation;
5. You received a certificate of rehabilitation;
6. The conviction was later dismissed, set aside or the sentence was suspended.

**NOTE:** IF THE CRIMINAL BACKGROUND CHECK REVEALS ANY CONVICTION(S) THAT YOU DID NOT DISCLOSE ON THIS FORM, YOUR FAILURE TO DISCLOSE THE CONVICTION(S) WILL RESULT IN AN EXEMPTION DENIAL, LICENSE APPLICATION DENIAL, LICENSE REVOCATION, OR EXCLUSION FROM A LICENSED FACILITY/ORGANIZATION.

**I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses and any accompanying attachments are true and correct.**

FACILITY/ORGANIZATION NAME		FACILITY/ORGANIZATION NUMBER	
YOUR NAME (PRINT CLEARLY)	YOUR ADDRESS	CITY	ZIP
SOCIAL SECURITY NUMBER (SEE PRIVACY STATEMENT ON REVERSE SIDE)	DATE OF BIRTH	DMV LICENSE NUMBER	
SIGNATURE		DATE	

## I. Instructions to Respondents:

If you have been convicted of a crime in California, another state or in federal court, provide the following information:

*(You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.)*

What was the offense? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In which state and city did you commit the offense? \_\_\_\_\_

\_\_\_\_\_

When did this occur? \_\_\_\_\_

\_\_\_\_\_

Tell us what happened. (Use additional sheets of paper if needed) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## II. Instructions to Licensees:

If the person discloses a criminal conviction, review the person's statement and discuss it with your Licensing Program Analyst (LPA). Maintain this form in your facility/organization personnel file and send a copy to your LPA.

### PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility/organization, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17, 1596.871, and 1796.19). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

#### NOTE: IMPORTANT INFORMATION

The Department is required to tell people who ask, including the press, if someone in a licensed facility/organization has a criminal record exemption. The Department must also tell people who ask, the name of a licensed facility/organization that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

## STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT SUSPECTED ABUSE OF DEPENDENT ADULTS AND ELDERS

*NOTE: RETAIN IN EMPLOYEE/ VOLUNTEER FILE*

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NAME

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POSITION

FACILITY

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California law **REQUIRES** certain persons to report known or suspected abuse of dependent adults or elders. As an employee or volunteer at a licensed facility, you are one of those persons - a "mandated reporter."

### PERSONS WHO ARE REQUIRED TO REPORT ABUSE

**Mandated reporters** include care custodians and any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not paid for that responsibility (Welfare and Institutions Code (WIC) Section 15630(a)). **Care custodian** means an administrator or an employee of most public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff (WIC Section 15610.17).

### PERSONS WHO ARE THE SUBJECT OF THE REPORT

**Elder** means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **Dependent Adult** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age and those admitted as inpatients in 24-hour health facilities (WIC Section 15610.23).

### REPORTING RESPONSIBILITIES AND TIME FRAMES

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect occurred, shall complete form SOC 341, "Report of Suspected Dependent Adult/Elder Abuse" for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult.

Reporting shall be completed as follows:

- If the abuse occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) and resulted in serious bodily injury (as defined in WIC Section 15610.67), report by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California

Department of Social Services) within two (2) hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, but did not result in serious bodily injury, report by telephone to the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local LTCOP, and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, was physical abuse, did not result in serious bodily injury, and was perpetrated by a resident with a physician's diagnosis of dementia, report by telephone to the local law enforcement agency or the local LTCOP, immediately or as soon as practicably possible. Follow by sending the written report to the LTCOP or the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, and was abuse other than physical abuse, report by telephone to the LTCOP or the law enforcement agency immediately or as soon as practicably possible. Follow by sending the written report to the local law enforcement agency or the LTCOP within two working days.
- If the abuse occurred in a state mental hospital or a state developmental center, mandated reporters shall report by telephone or through a confidential internet reporting tool (established in WIC Section 15658) immediately or as soon as practicably possible and submit the report within two (2) working days of making the telephone report to the responsible agency as identified below:
  - If the abuse occurred in a State Mental Hospital, report to the local law enforcement agency or the California Department of State Hospitals.
  - If the abuse occurred in a State Developmental Center, report to the local law enforcement agency or to the California Department of Developmental Services.
- For all other abuse, mandated reporters shall report by telephone or through a confidential internet reporting tool to the adult protective services agency or the local law enforcement agency immediately or as soon as practicably possible. If reported by telephone, a written or an Internet report shall be sent to adult protective services or law enforcement within two working days.

## **PENALTY FOR FAILURE TO REPORT ABUSE**

Failure to report abuse of an elder or dependent adult is a MISDEMEANOR CRIME, punishable by jail time, fine or both (WIC Section 15630(h)). The reporting duties are individual, and no supervisor or administrator shall impede or inhibit the reporting duties, and no person making the report shall be subject to any sanction for making the report (WIC Section 15630(f)).

## **CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS**

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only



among APS agencies, local law enforcement agencies, LTCOPs, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order. Any violation of confidentiality is a misdemeanor punishable by jail time, fine, or both (WIC Section 15633(a)).

## DEFINITIONS OF ABUSE

**Physical abuse** means any of the following: (a) Assault, as defined in Section 240 of the Penal Code; (b) Battery, as defined in Section 242 of the Penal Code; (c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code; (d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water; (e) Sexual assault, that means any of the following: (1) Sexual battery, as defined in Section 243.4 of the Penal Code; (2) Rape, as defined in Section 261 of the Penal Code; (3) Rape in concert, as described in Section 264.1 of the Penal Code; (4) Spousal rape, as defined in Section 262 of the Penal Code; (5) Incest, as defined in Section 285 of the Penal Code; (6) Sodomy, as defined in Section 286 of the Penal Code; (7) Oral copulation, as defined in Section 288a of the Penal Code; (8) Sexual penetration, as defined in Section 289 of the Penal Code; or (9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code; or (f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions: (1) For punishment; (2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given; or (3) For any purpose not authorized by the physician and surgeon (WIC Section 15610.63).

**Serious bodily injury** means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation (WIC Section 15610.67).

**Neglect** (a) means either of the following: (1) The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise; or (2) The negligent failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise. (b) Neglect includes, but is not limited to, all of the following: (1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter; (2) Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment; (3) Failure to protect from health and safety hazards; (4) Failure to prevent malnutrition or dehydration; or (5) Failure of an elder or dependent adult to satisfy the needs specified in paragraphs (1) to (4), inclusive, for himself or herself as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health (WIC Section 15610.57).

**Financial abuse** of an elder or dependent adult occurs when a person or entity does any of the following: (1) Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; (2) Assists in taking, secreting, appropriating, obtaining, or retaining real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; or (3) Takes, secretes, appropriates, obtains, or

retains, or assists in taking, secreting, appropriating, obtaining, or retaining, real or personal property of an elder or dependent adult by undue influence, as defined in Section 15610.70 (WIC Section 15610.30(a)).

**Abandonment** means the desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody (WIC Section 15610.05).

**Isolation** means any of the following: (1) Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls; (2) Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons; (3) False imprisonment, as defined in Section 236 of the Penal Code; or (4) Physical restraint of an elder or dependent adult, for the purpose of preventing the elder or dependent adult from meeting with visitors (WIC Section 15610.43).

**Abduction** means the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, of any elder or dependent adult who does not have the capacity to consent to the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, as well as the removal from this state or the restraint from returning to this state, of any conservatee without the consent of the conservator or the court (WIC Section 15610.06).

AS AN EMPLOYEE OR VOLUNTEER OF THIS FACILITY, YOU MUST COMPLY WITH THE DEPENDENT ADULT AND ELDER ABUSE REQUIREMENTS, AS STATED ABOVE. IF YOU DO NOT COMPLY, YOU MAY BE SUBJECT TO CRIMINAL PENALTY. IF YOU ARE A LONG-TERM CARE OMBUDSMAN, YOU MUST COMPLY WITH FEDERAL AND STATE LAWS, WHICH PROHIBIT YOU FROM DISCLOSING THE IDENTITIES OF LONG-TERM RESIDENTS AND COMPLAINANTS TO ANYONE UNLESS CONSENT TO DISCLOSE IS PROVIDED BY THE RESIDENT OR COMPLAINANT OR DISCLOSURE IS REQUIRED BY COURT ORDER (Title 42 United States Code Section 3058g(d)(2); WIC Section 9725).

I, \_\_\_\_\_, have read and understand my responsibility to report known or suspected abuse of dependent adults or elders. I will comply with the reporting requirements.

SIGNATURE	DATE



Redwood Highway A14, San Rafael, CA 94903  
Phone: 415-479-5125 Fax: 415-479-5196

### **EMPLOYMENT AGREEMENT**

**THIS EMPLOYMENT AGREEMENT** ("Agreement") is made and entered into, as of \_\_\_\_\_ ("Effective Date"), by and between **Acclaim Homecare/Acclaim Professional Healthcare LLC**, a California limited liability company ("Company"), with its business headquarters located at 4340 Redwood Highway A14, San Rafael, CA, 94903, and \_\_\_\_\_ ("Employee"), with address located at \_\_\_\_\_.

**WHEREAS**, Company is engaged in the business of providing home care services to assist activities of daily living for Company's clients and other persons, and

**WHEREAS**, Company desires to employ or continue to employ Employee, and Employee desires to be employed or continue to be employed by Company, to provide home care services to assist activities of daily living for Company's clients, until such employment is terminated in accordance with the terms of this Agreement.

**NOW, THEREFORE**, Company and Employee covenant and agree as follows:

#### **1. Duties.**

- a. Employee warrants to Company that the Employee has the required skills, experience, and license if required by law, to perform the duties of and required for the position described on the Addendum attached hereto in accordance with generally accepted industry standards.
- b. Employee warrants and represents that Employee has the legal right to work in the United States.

- c. Employee warrants and represents that Employee has the ability to enter into this Agreement; that entering into and performing under this Agreement will not violate Employee's agreement with any third party; and that there exists no restrictions or obligations to any third party which would restrict Employee's performance of his/her duties under this Agreement.
- d. Employee shall comply with all lawful and reasonable instructions given by superiors or other authorized employees representing Company.
- e. Employee shall comply with all stated standards of performance, policies, rules, and regulations of Company, including executing additional documents and completing required training. Employee acknowledges that they have received the Company's Policy and Procedures, that Employee has read them thoroughly, agrees to abide by them, and understands that failure to follow them may result in termination. Employee shall also comply with current or future policies, rules, regulations, performance standards, and manuals of the Company which may be published or amended from time to time.
- f. Employee's job duties shall be rendered at such places as Company shall assign to Employee to provide services to clients. Employee may be required to use his or her own automobile to transport clients to and from certain activities, and Employee shall be reimbursed for the cost of mileage for such automobile use based on the standard mileage rate prescribed by the Internal Revenue Service.
- g. Employee shall not during the term of employment: (i) enter into any agreement that conflicts with the Employee's duties or obligations to the Company; (ii) directly or indirectly solicit or encourage any other employee, agent, independent contractor, supplier, customer, consultant, or any other person or company to terminate or detrimentally alter a relationship with Employer; (iii) disparage the Company or its business or employees, agents, contractors, suppliers, customers, or consultants.
- h. Employee shall be obligated to obtain business permits and/or licenses where required by any state or local laws, ordinance, or regulation prior to engaging in the work assignment referred to Employee by Company.
- i. If Employee performs services as a live-in employee, Employee shall be entitled to have at least twelve (12) consecutive hours free of duty during each workday of 24 hours. If Employee is required to work during the 12-hour duty-free period, Employee must obtain prior written authorization from Company to perform such work, except in an emergency.

- j. Employee acknowledges that they will be providing in-home, non-medical care to clients. Employee agrees not to perform services which are outside the scope of Employee's duties and responsibilities as authorized and assigned by Company of for services which may be performed with professional licenses which Employee does not possess.

## **2. At-Will Employment**

Employee's employment with Company is "at will," subject to applicable law, and that either Company or Employee may terminate employment at any time, with two (2) weeks' prior written notice to the other, for any reason or no reason whatsoever. Nothing in this Agreement shall constitute a promise of employment for any particular duration or specific rate of pay.

## **3. Compensation and Benefits**

As payment for the services rendered to Company by Employee, Company shall pay for and provide the compensation and benefits, if any, to Employee as stated in Exhibit A attached hereto and incorporated herein by this reference. Exhibit A shall also include a list of property belonging to Company which Company has allowed Employee to use in the ordinary course of business. Other than the compensation and benefits provided herein, Employee shall not be entitled to any other bonuses, incentives or benefits Company may provide to its other employees. Any change in compensation or benefits to be provided to Employee shall be in writing and signed by both Employee and an authorized officer of Company.

## **4. Job Duties**

- a. Employee is responsible for the overall care for specifically assigned patients.
- b. Employee is responsible for learning, implementing and maintaining the core values of the Company.
- c. Employee is responsible for delivering first class service excellence to each and every client assigned to Employee by Company.
- d. Employee is responsible for communicating all schedule changes, concerns, and any other care-related issue directly to the Care Manager for each client they have been assigned to.
- e. Employee is responsible for complying with the documentation requirements set forth in the Company's standard documentation system.
- f. Employee is responsible for studying and carrying out each "Care Plan" in detail for each client Employee is assigned to.
- g. Employee is responsible and accountable for accurately and honestly clocking-in and clocking-out using the Company's timekeeping system.

- h. Employee is expected to perform the duties that are outlined in each Care Plan. Employee understands that if there is any concern with any of the duties listed below, that they will immediately express the concern to the Field Supervisor who can assist with additional training on any of the items:

- (1) Companionship
- (2) Laundry
- (3) Light housekeeping
- (4) Meal planning and preparation
- (5) Bathing/Showering assistance
- (6) Personal hygiene
- (7) Errands & shopping
- (8) Incidental transportation
- (9) Medication reminders
- (10) Incontinence-related duties
- (11) Additional duties that may be requested

## **5. Code of Conduct**

### **A. Standard of Care**

- (1) Inappropriate language, jokes, and the like are prohibited. Such actions present a very unprofessional image and reflect poorly on the Company and Employee.
- (2) Employee must never discuss salary/wages with anyone but with Company management. This information is confidential and is never to be shared with clients or other caregivers. Sharing such confidential information with others may result in termination of employment.
- (3) Employee is prohibited from soliciting any type of other business like multi-level marketing, direct marketing, etc. to company clients or family members while employed by Company. Any violation may result in immediate termination.
- (4) Perfumes/colognes should be kept to a minimum as many clients are allergic and/or sensitive to fragrances.
- (5) No open-toed shoes, high heel shoes, sandals, or shoes without full ankle support and toe covering are allowed while on the job. This may cause risk of injury to Employee and client. Tennis shoes or medical professional shoes should be worn.
- (6) Employee must not wear revealing outfits i.e. tube tops, shorts, tank tops, and the like.

## **B. Company's Core Values**

### **(1) Professional Care**

- a) Employee shall never discuss with a client or their family members personal matters which would appear unprofessional by the Company's standards. Such personal matters can place a client in an awkward position and create a negative atmosphere for Company and Employee.
- b) Employee shall always be professional and respect the client's property and privacy.
- c) Employee shall NEVER give a client's phone number to anyone, including Employee's own family. If a third party needs to contact Employee, Employee should leave instructions that the caller contact Company first and Company will contact Employee at the client's home if it is an emergency.
- d) Employee shall never give personal information, including Employee's address and phone number, to any client or client's family member. When asked, Employee shall tell them to contact Employer at Employer's office number.
- e) Employee shall never call a client directly, unless authorized by Company in advance.
- f) Employee shall not smoke on their way to work or during a shift. If Employee's shift is more than 4 hours, Employee is allowed to smoke during the 10-minute break period and only outside the client's house. Employee shall also ensure that their clothes do not smell of smoke while on a shift.
- g) Employee shall turn their cell phone off while at a client's house and shall NEVER make or take personal calls while working on a shift unless otherwise authorized by Company.
- h) Employee shall not speak disparagingly of the Company, its employees or other caregivers to clients, client's family members, or another employee or caregiver. If Employee has an issue with Company, another employer or caregiver, Employee should discuss any grievances or concerns with the Care Director.
- i) Employee understands that, as an employee of Company and not the client, all care-related issues must be communicated directly with the Care Manager and not the client.
- j) Employee understands that their direct supervisor is the Field Supervisor responsible for the client Employee is assigned to. In some instances Employee may report to more than one Field Supervisor if Employee is assigned to care for more than one client.
- k) Employee shall respect the authority of the Field Supervisors and comply with their requests or instructions as long as they do not violate any Company policy or procedure or the law. Should Employee have a concern with any of the Field Supervisors, Employee understands that they can express this to Company management.

- 1) Employee shall be responsible and respectful at all times in the performance of their duties and obligations to the client. Employee shall comply with all laws, statutes, ordinances, ethical codes, Company policies and procedures, rules or regulations, including but not limited to those prohibiting sexual harassment, discrimination, and unfair business practices. Employee shall conduct themselves at all times to conform to the highest professional and ethical standards in providing home care services to Client. Company is obligated to report any suspected abuse whether it be verbal, physical, emotional, mental, sexual or financial, to law enforcement and the appropriate governmental agencies.

## **(2) Consistent Care**

- a) Employee shall follow each Care Plan and ensure that clients receive the same high level of care during each and every visit.
- b) Employee shall always accurately fill out their timesheet and submit it to the Company in a timely manner. Employee understands that failure to do so may result in not getting paid for that particular shift and in some instances may result in termination.
- c) Employee understands that Company will not tolerate tardiness. Employee agrees to be on time for each and every shift and understands that excessive tardiness will result in termination.
- d) Employee shall not request excessive days off while on work assignments with clients.
- e) Before Employee takes any day off while engaged in a work assignment for a client, Employee shall be obligated to notify the Company at least ten (10) business days, or two weeks, in advance of the time Employee needs the time off, unless there is an emergency or unusual circumstances. Failure to comply with this rule may result in disciplinary action, including immediate termination.
- f) Employee shall document the duties performed for the client in the documentation logs at the end of each visit. The documentation shall include tasks performed for the client. Employee shall note/narrate all duties, not included on the documentation checklist, in the notes section of the documentation logs. Such narrative notes shall be written legibly so as to be readable and clear for the Field Supervisor. Failure to provide proper documentation during each and every shift may lead to disciplinary action including termination.
- g) Employee shall keep their employee file up to date. This includes a yearly driving record, auto insurance (whenever it is renewed), tuberculosis (TB) tests, and all other necessary documentation as requested by the Company.
- h) Employee shall use their best efforts to be proactive when working with clients so that Employee would never leave a client's home without it looking better than when Employee started their shift. That includes a clean kitchen, bedrooms, bathrooms, etc., if requested in the Care Plan.
- i) Whenever possible, Employee agrees to fill-in for other caregivers who are unable to work their scheduled shift with the understanding that other caregivers may need to cover Employee's shift at some future date. Employee agrees to always communicate and respond to such requests or fill-ins to the Company's office immediately.



- j) Employee understands that if they are found to be using drugs or alcohol while on the job, or shows up for work in an intoxicated state, these are grounds for immediate termination and even legal action if State and/or Federal laws have been violated.
- k) Employee understands that if they fail to report to work when required and fails to notify the Company in advance of an absence, this will constitute Employee voluntarily quitting their job without notice and shall be subject to immediate termination. If Employee is licensed as a Certified Nursing Assistant (CNA) or other licensed healthcare professional, Company reserves the right to report this failure to appear for work without notice as client abandonment to the State Health Department, which may result in the Employee losing their applicable license.

### **(3) Honest Care with Integrity**

- a) Employee shall always be honest to Company and its clients.
- b) Employee understands that all client information in the care plan is confidential and must not be shared with others outside of Company purposes.
- c) Employee shall never take advantage of Company's clients in any way.
- d) Employee shall always strive to fulfill their responsibilities outlined in each client's Care Plan.
- e) Employee shall always be honest when documenting, at the end of each shift, what Employee did for the client that day.
- f) Employee shall not solicit a client of the Company for private care or for any other services or products.
- g) Employee shall always strive to adhere to Company's mission of "performing my duties with honesty, integrity, confidence, concern, commitment, cheerfulness, compassion, consistency, and care. I will treat every client as a friend and perform each task as if they were family.
- h) Employee shall treat each client with respect and dignity and remember that they are adults.

## **6. Non-disclosure of Trade Secrets, Customer Lists and Other Proprietary Information**

Employee agrees not to disclose or communicate, in any manner, either during or after Employee's employment with Company, proprietary information about Company, its operations, clientele, or any other proprietary information, that relate to the business of Company including, but not limited to, the names of its clients, customers, its marketing strategies, operations, or any other information of any kind which would be deemed confidential, a trade secret, a customer list, or other form of proprietary information of Company. Employee acknowledges that the above information is material and confidential and that it affects the profitability of Company. Employee understands that any breach of this provision, or that any breach of this provision, or that of any other Confidentiality and Non-Disclosure Agreement, is a material breach of this Agreement. To the extent Service Provider determines that it is necessary to disclose confidential information, they may do so only after obtaining written authorization from an officer of the Company.

## **7. Non-solicitation and Non-recruit Covenants**

Employee agrees that all clients or customers of Company, for which Employee has or will provide services during Employee's employment with Company, shall be solely the clients or customers of Company and shall their names and identities shall constitute confidential information and trade secrets. Employee shall not, while employed by Company and for a period of *one year* immediately following termination of Employee's employment with Company, either directly or indirectly, call on, solicit, or take away, or attempt to call on, solicit, or take away, any of the customers or clients of the Company, either for their own benefit, or for the benefit of any other person, party or entity. In addition to the foregoing, Employee shall not, during this Agreement and for a period of *one year* immediately following termination of employment with Company, either directly or indirectly, recruit any of Company's employees for the purpose of any outside business.

## **8. Reasonableness of Restrictions**

- a. Employee has carefully read and considered the provisions stated hereinabove and, having done so, agrees that the restrictions set forth therein, including the time period of restriction and the geographical areas of restriction, if any, are fair and reasonable and are reasonably required for the protection of the interests of the Company.
- b. In the event that, notwithstanding the foregoing, any part of the covenants set forth hereinabove shall be held to be invalid or unenforceable, the remaining parts thereof shall nevertheless continue to be valid and enforceable as though the invalid or unenforceable parts had not been included therein. In the event that any provision set forth hereinabove relating to time period and/or areas of restriction, if any, shall be declared by a court of competent jurisdiction to exceed the maximum time period or areas such court deems reasonable and enforceable, the agreed upon time period and/or areas which such court deems reasonable and enforceable.

## **9. Return of Property**

On termination of employment with Company, or whenever requested by Company, Employee shall immediately deliver to Company all property in Employee's possession, or under their care and control, belonging to Company, including but not limited to, proprietary information, customer lists, trade secrets, intellectual property, computers, equipment, tools, documents, plans, recordings, software, and all related records or accounting ledgers.

## **10. Consumer Reports**

Company may require Employee's consent to obtain a consumer report on Employee in connection with Employee's initial application for employment, an application for a new position in the Company, or an investigation into possible wrongful conduct by Employee. A consumer report may contain information regarding Employee's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. The Company will use this information for employment purposes only. Refusal to authorize the obtaining of a consumer report by the Company may be the basis for denial of employment or other adverse employment action. The contents of the consumer report may also be the basis for denial of employment, denial of a particular job position, or other adverse action. Employee will be advised if the Company elects to take adverse employment action against Employee based in whole or in part on a consumer report.

## **11. Entire Agreement**

This Agreement embodies the entire understanding between the parties hereto and supersedes and replaces any and all prior understandings, arrangements, and/or agreements, whether written or oral, relating to the subject matter hereof.\

## **12. Amendment/Waiver**

a. No waiver or modification of this Agreement or of any covenant, condition, or limitation herein contained shall be valid unless in writing and duly executed by the party to be charged therewith. Furthermore, no evidence or any waiver or modification shall be offered or received in evidence in any proceeding, arbitration, or litigation between the parties arising out of or affecting this Agreement, or the rights or obligations of any party hereunder, unless such waiver or modification is in writing, duly executed as aforesaid. The provisions of this Section may not be waived except as herein set forth.

b. Failure to exercise of delay in exercising any right, power or privilege of that party under this Agreement on the part of either party hereto shall not in any circumstances operate as a waiver of any such rights, powers, or privileges, not prejudice either party's rights to take subsequent action.

## **13. Notices**

a. Any notice required to be given to Employee hereunder shall be sufficiently given if delivered to Employee personally, or if mailed by United States first class certified mail, return receipt requested, to Employee's address last known to Company. It is Employee's responsibility to keep his/her contact information up-to-date with Company.

b. Any notice required to be given to Company hereunder shall be sufficiently given if delivered to an officer of Company personally, or if mailed by United States first class certified mail, return receipt requested, to Company's business address.

c. Any notice given in accordance with this Section shall be deemed to be received by the recipient on the fourth business day after mailing if sent by United States certified mail, and on the day of delivery, if delivered personally.

## **14. Choice of Law and Jurisdiction**

This Agreement and the parties' actions under this agreement shall be governed by and construed under the laws of the State of California without reference to conflict of law principles. The parties herein waive trial by jury and agree to submit to the personal jurisdiction and venue of a court of subject matter jurisdiction located in Marin County, State of California. Each party irrevocably waives to the fullest extent allowed by applicable law, the defense of an inconvenient forum in any such action or proceeding.

## **15. Inadequate Legal Remedy**

Both parties understand and acknowledge that violation of their respective covenants and agreements herein may cause the other irreparable harm and damage, that may not be recovered at law, and each

agrees that the other's remedies for breach may be in equity by way of injunctive relief, as well as for damages and any other relief available to the non-breaching party, whether at law or in equity.

## **16. Arbitration**

Any dispute relating to the interpretation or performance of this Agreement shall be resolved at the request of either party through binding arbitration. Arbitration shall be conducted in Marin County, State of California, in accordance with the then-existing rules of the American Arbitration Association. Judgment upon any award by the arbitrators may be entered by any state or federal court having jurisdiction. Both parties intend that this agreement to arbitrate be irrevocable.]

## **17. Non-Assignability**

Except as otherwise provided for within this Agreement, Employee may not assign any of his/her rights or delegate any of his/her obligations under this Agreement to any third party without the express written permission of Company. Any such assignment is deemed null and void.

## **18. Severability**

If any provisions of this Agreement is held by a court of competent jurisdiction to be invalid under any applicable statute or rule of law, they are to that extent to be deemed omitted and the remaining provisions of this Agreement shall remain in full force and effect.

## **19. Cumulative Rights**

Any specific right or remedy provided in this Agreement will not be exclusive but will be cumulative upon all other rights and remedies described in this Section and allowed under applicable law.

## **20. Headings**

The titles and headings of the various sections and sections in this Agreement are intended solely for convenience of reference and are not intended for any other purpose whatsoever, or to explain, modify or place any construction upon or on any of the provisions of this Agreement.

## **21. Execution of Additional Documents**

The parties hereto agree to promptly execute and deliver such documents which are reasonably required to be executed by a party to effectuate this Agreement.

## **22. Drafting**

This Agreement has been fully reviewed and negotiated by the parties; accordingly, any uncertainty or ambiguity shall not be construed for or against any party based on attribution of drafting to said party.

## **23. Counterparts**

This Agreement may be signed in two counterparts, provided that each party receives a copy fully executed by the other party.

## **24. Survival of Certain Provisions**

The warranties and the indemnification and confidentiality obligations set forth in the Agreement shall survive the termination of the Agreement by either party for any reason.

## **25. Acknowledgement**

EACH PARTY THAT SIGNS THIS AGREEMENT REPRESENTS AND WARRANTS THAT THEY HAVE CAREFULLY READ AND FULLY UNDERSTANDS THIS AGREEMENT AND ITS FINAL AND BINDING EFFECT; HAS BEEN AFFORDED SUFFICIENT TIME AND OPPORTUNITY TO REVIEW THIS AGREEMENT WITH ADVISORS OR ATTORNEYS OF HIS OR HER CHOICE; HAS HAD AN OPPORTUNITY TO NEGOTIATE WITH REGARD TO THE TERMS OF THIS AGREEMENT; IS FULLY COMPETENT TO MANAGE HIS OR HER OWN BUSINESS AFFAIRS AND TO ENTER INTO OR SIGN THIS AGREEMENT; HAS SIGNED THIS AGREEMENT KNOWINGLY, FREELY, AND VOLUNTARILY.

**COMPANY:**  
**ACCLAIM HOMECARE, INC/  
ACCLAIM PROFESSIONAL  
HEALTHCARE, LLC**

**EMPLOYEE:**

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**Company Representative**

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**Print Name**

---

**Signature**

---

**Signature**

---

**Date**

---

**Date**

### **ADDENDUM TO EMPLOYMENT AGREEMENT**

This Addendum to Employment Agreement ("Addendum") is made as of \_\_\_\_\_, by and between Acclaim Professional Healthcare LLC, a California limited liability company, "Employer," and \_\_\_\_\_ ("Employee"), to supplement, modify, and amend that Employment Agreement between Employer and Employee dated \_\_\_\_\_ ("Agreement").

Employer and Employee hereby agree as follows:

1. Employer shall heretofore no longer provide live-in home care services to its clients.
2. In the event Employee decides to stay overnight at the home of the client Employee is providing home care services to while Employee is off-duty and in between work shifts, said overnight stay shall be at the sole discretion and volition of the Employee and shall be subject to the permission of the client in whose home the overnight stay occurs. Employee shall not be authorized to perform any work or services to or on behalf of the client, and client is prohibited by Employer from requesting Employee to perform any work or services during Employee's off-duty period. In the event Employee decides on his/her own volition to remain on the client's premises during the off-duty period, all work and services shall be performed by the other caregiver/employee who is on duty. In case of emergency during the off-duty period, Employee shall have no obligation to render assistance. It is Employee's policy that the caregiver or employee who is on duty should call 911.
3. Until subsequent written notice from Employer to Employee, Employee shall be compensated at the rate of \$\_\_\_\_ per hour of work. Overtime would be paid in accordance with applicable law.
4. In all other respects, the terms and conditions stated in the Agreement shall continue in full force and effect.

IN WITNESS WHEREOF, Employer and Employee have executed this Addendum as of the date written hereinabove.

**EMPLOYER:**

ACCLAIM HOMECARE, INC./ACCLAIM  
PROFESSIONAL HEALTHCARE, LLC.

**Signed By:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**EMPLOYEE:**

**Signed By:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Tel. No.:** \_\_\_\_\_

## **ARBITRATION AGREEMENT**

### **ADDENDUM TO EMPLOYMENT AGREEMENT**

This Arbitration Agreement is entered into by and between Company and Employee and is hereby incorporated and made a part of that Employment Agreement entered into by and between Company and Employee dated \_\_\_\_\_.

1. **Binding Arbitration.** The Company and Employee agree and acknowledge that the Company and Employee will utilize binding arbitration to resolve all disputes that may arise out of the employment context. Both the Company and Employee agree that any claim, dispute, and/or controversy that either the Employee may have against the Company (or its owners, directors, officers, managers, employees, agents, and parties affiliated with its employee benefit and health plans) or the Company may have against the Employee, arising from, related to, or having any relationship or connection whatsoever with the Employee's employment by, or other association with the Company shall be submitted to and determined exclusively by binding arbitration under the Federal Arbitration Act, in conformity with the procedures of the California Arbitration Act (Cal. Code Civ. Proc. Sec 1280 et seq., including section 1238.05 and all of the Act's other mandatory and permissive rights to discovery).

2. **Scope of Agreement.** Included within the scope of this Agreement are all disputes relating to employment, the terms and conditions of employment, including but not limited to compensation, wages, claims alleging failure to compensate for all hours worked, failure to pay overtime, failure to pay minimum wage, failure to reimburse expenses, failure to pay wages upon termination, failure to provide accurate, itemized wage statements, failure to provide meal and/or breaks, entitlement to waiting time penalties and/or other claims involving employee wages, benefits, discipline, performance evaluations, promotions, transfers, and the termination of employment. Disputes which are also subject to this Agreement shall include but not limited to the following: (a) alleged violations of federal, state and/or local constitutions, statutes or regulations, (including but not limited to claims under Title VII of the Civil Rights Act of 1964, the Americans with Disabilities Act, the Age Discrimination in Employment Act of 1967, the Equal Pay Act, and any other statutory scheme encompassing claims of discrimination and harassment on the basis of race, color, age, religious creed, national origin, ancestry, disability, sexual orientation, gender identity, sex or any other characteristic protected by law); (b) claims based on any purported breach of contractual obligation, including breach of the covenant of good faith and fair dealing including but not limited to claims of wrongful termination or constructive termination; (c) claims based on any purported breach of duty arising in tort, including violations of public policy, for emotional distress and defamation; and (d) claims related to the payment or non-payment of wages, expenses and/or the provisions of breaks as required by law, including, but not limited to, alleged violations of the Fair Labor Standards Act and any other statutory scheme governing wages.

3. Exclusions from Arbitration. Excluded from the application of this Agreement are (a) claims for workers' compensation and unemployment insurance benefits; and disputes or claims that are expressly excluded by statute or are expressly required to be arbitrated under a different procedure pursuant to the terms of an employee benefit plan. Nothing herein shall be intended to preclude Employee from filing a claim with a state or federal administrative agency, such as the Equal Employment Opportunity Commission or the National Labor Relations Board. A state or federal administrative agency shall also be free to pursue any appropriate action. However, any claim that is not resolved administratively through such an agency shall be subject to this Agreement. Nothing herein is intended to require arbitration of any claim or dispute which the courts of this jurisdiction have expressly held are not subject to mandatory arbitration.

4. Arbitration Proceedings. The arbitration shall be conducted in accordance with the provisions and procedures set forth in the Employment Arbitration Rules and Mediation Procedures of the American Arbitration Association. The arbitrator shall have the same authority to award remedies and damages on the merits of the dispute as provided to a judge and/or jury under parallel circumstances. However, the arbitrator shall only be permitted to award those remedies in law or equity which are requested by the parties and which are supported by credible, relevant evidence. The arbitrator shall issue a written opinion and award.

5. Waivers. Company and Employee understand and agree to this binding arbitration provision, and both Company and Employee give up their right to trial by jury of any claim either party may have against the other. No arbitrator or court may order, permit or certify a class action, representative action, private attorney general litigation, or consolidated arbitration in connection with this Agreement. **Furthermore, by accepting this Agreement, Employee hereby agrees to waive his or her right to initiate, join or participate in a class action or representative action, or act as a private attorney general or representative of others, or otherwise consolidate a covered claim with the claims of others.**

6. Fees and Costs. Each party shall be responsible for its own attorney's fees and expenses, except as otherwise provided by law, and the cost of the arbitrator's fee and expenses and any costs associated with the facilities for the arbitration.

7. Entire Agreement. This is the entire agreement between the Company and Employee regarding dispute resolution with respect to any issues which may arise in connection with Employee's employment, and this Agreement supersedes any and all prior agreements regarding these issues. It is further agreed and understood that any agreement contrary to the foregoing must be entered into, in writing, by the Employee and an authorized officer of the Company.

8. Mediation and Severability. Nothing herein shall preclude the parties from discussing a mutually acceptable resolution of the dispute without the necessity of formal arbitration proceedings. The parties may agree to engage in mediation prior to arbitration. If any term or provision, or portion of this Agreement is declared void or unenforceable, it shall be severed and the remainder of this Agreement shall be enforceable.



**9. FINAL AND BINDING ARBITRATION. IN CONSIDERATION FOR AND AS A MATERIAL CONDITION OF EMPLOYMENT WITH THE COMPANY, AND IN CONSIDERATION FOR THE COMPANY'S RETURN AGREEMENT TO BE BOUND BY THE TERMS OF THIS AGREEMENT AND HAVE ANY AND ALL CLAIMS ARISING OUT OF THE EMPLOYMENT RELATIONSHIP THE COMPANY MAY HAVE TO BE RESOLVED PURSUANT TO THIS AGREEMENT, AND PAY THE ARBITRATION FEES AS DESCRIBED HEREIN, IT IS AGREED THAT THIS AGREEMENT, WHICH PROVIDES FOR FINAL AND BINDING ARBITRATION, SHALL BE THE EXCLUSIVE MEANS FOR RESOLVING COVERED DISPUTES; NO OTHER ACTION MAY BE BROUGHT IN COURT OR IN ANY OTHER FORUM. EMPLOYEE UNDERSTANDS THAT THIS AGREEMENT IS A WAIVER OF ALL RIGHTS TO A CIVIL COURT ACTION FOR ALL DISPUTES RELATING TO HIS OR HER EMPLOYMENT, THE TERMS OF EMPLOYMENT BROUGHT BY THE EMPLOYEE OR THE COMPANY; ONLY AN ARBITRATOR, NOT A JUDGE OR JURY, WILL DECIDE THE DISPUTE. IN ADDITION, EMPLOYEE UNDERSTANDS THAT HE OR SHE IS PROHIBITED FROM JOINING OR PARTICIPATING IN A CLASS ACTION OR REPRESENTATIVE ACTION, ACTING AS A PRIVATE ATTORNEY GENERAL OR REPRESENTATIVE OF OTHERS, OR OTHERWISE CONSOLIDATING A COVERED CLAIM WITH THE CLAIM OF OTHERS.**

**EMPLOYEE'S SIGNATURE BELOW ATTESTS TO THE FACT THAT EMPLOYEE HAS READ, UNDERSTANDS, AND AGREES TO BE LEGALLY BOUND TO ALL OF THE ABOVE TERMS.**

**COMPANY:  
ACCLAIM HOMECARE, INC/ ACCLAIM  
PROFESSIONAL HEALTHCARE, LLC**

**EMPLOYEE:**

\_\_\_\_\_  
**Company Representative**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**

**NOTICE TO EMPLOYEE**  
***Labor Code section 2810.5***

**EMPLOYEE**

Employee Name: \_\_\_\_\_

Start Date: \_\_\_\_\_

**EMPLOYER**

Legal Name of Hiring Employer: \_\_\_\_\_

Is hiring employer a staffing agency/business (e.g., Temporary Services Agency; Employee Leasing Company; or Professional Employer Organization [PEO])? ☐ Yes ☐ No

Other Names Hiring Employer is "doing business as" (if applicable):  
\_\_\_\_\_

Physical Address of Hiring Employer's Main Office:  
\_\_\_\_\_

Hiring Employer's Mailing Address (if different than above):  
\_\_\_\_\_

Hiring Employer's Telephone Number: \_\_\_\_\_

If the hiring employer is a staffing agency/business (above box checked "Yes"), the following is the other entity for whom this employee will perform work:

Name: \_\_\_\_\_

Physical Address of Main Office: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**WAGE INFORMATION**

Rate(s) of Pay: \_\_\_\_\_ Overtime Rate(s) of Pay: \_\_\_\_\_

Rate by (check box): ☐ Hour ☐ Shift ☐ Day ☐ Week ☐ Salary ☐ Piece rate ☐ Commission

☐ Other (provide specifics): \_\_\_\_\_

Does a written agreement exist providing the rate(s) of pay? (check box) ☐ Yes ☐ No

If yes, are all rate(s) of pay and bases thereof contained in that written agreement? ☐ Yes ☐ No

Allowances, if any, claimed as part of minimum wage (including meal or lodging allowances):  
\_\_\_\_\_

(If the employee has signed the acknowledgment of receipt below, it does not constitute a "voluntary written agreement" as required under the law between the employer and employee in order to credit any meals or lodging against the minimum wage. Any such voluntary written agreement must be evidenced by a separate document.)

Regular Payday: \_\_\_\_\_

## WORKERS' COMPENSATION

Insurance Carrier's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Policy No.: \_\_\_\_\_  
☐ Self-Insured (Labor Code 3700) and Certificate Number for Consent to Self-Insure: \_\_\_\_\_

## PAID SICK LEAVE

Unless exempt, the employee identified on this notice is entitled to minimum requirements for paid sick leave under state law which provides that an employee:

- a. May accrue paid sick leave and may request and use up to 3 days or 24 hours of accrued paid sick leave per year;
- b. May not be terminated or retaliated against for using or requesting the use of accrued paid sick leave; and
- c. Has the right to file a complaint against an employer who retaliates or discriminates against an employee for
  1. requesting or using accrued sick days;
  2. attempting to exercise the right to use accrued paid sick days;
  3. filing a complaint or alleging a violation of Article 1.5 section 245 et seq. of the California Labor Code;
  4. cooperating in an investigation or prosecution of an alleged violation of this Article or opposing any policy or practice or act that is prohibited by Article 1.5 section 245 et seq. of the California Labor Code.

The following applies to the employee identified on this notice: *(Check one box)*

- ☐ 1. Accrues paid sick leave only pursuant to the minimum requirements stated in Labor Code §245 et seq. with no other employer policy providing additional or different terms for accrual and use of paid sick leave.
- ☐ 2. Accrues paid sick leave pursuant to the employer's policy which satisfies or exceeds the accrual, carryover, and use requirements of Labor Code §246.
- ☐ 3. Employer provides no less than 24 hours (or 3 days) of paid sick leave at the beginning of each 12-month period.
- ☐ 4. The employee is exempt from paid sick leave protection by Labor Code §245.5. (State exemption and specific subsection for exemption): \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT

\_\_\_\_\_  
(PRINT NAME of Employer representative)

\_\_\_\_\_  
(PRINT NAME of Employee)

\_\_\_\_\_  
(SIGNATURE of Employer Representative)

\_\_\_\_\_  
(SIGNATURE of Employee)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Date)

The employee's signature on this notice merely constitutes acknowledgement of receipt.

Labor Code section 2810.5(b) requires that the employer notify you in writing of any changes to the information set forth in this Notice within seven calendar days after the time of the changes, unless one of the following applies: (a) All changes are reflected on a timely wage statement furnished in accordance with Labor Code section 226; (b) Notice of all changes is provided in another writing required by law within seven days of the changes.



Redwood Highway A14  
San Rafael, CA 94903  
Phone: 415-479-5125 Fax: 415-479-5196  
[www.acclaimhomecare.com](http://www.acclaimhomecare.com)



## **ACCLAIM HOMECARE/ACCLAIM PROFESSIONAL EMPLOYEES**

1. Follow recommended care instructions when working with the client or client's family/friends. Perform the required tasks while always following Acclaim's protocols and procedures.
2. Perform tasks efficiently.
3. Involve the client whenever possible with all activities.
4. Execute activities of daily living (ADLs) like bathing, dressing, feeding, etc., with respect for the privacy and dignity of all your clients.
5. Prepare nutritional meals, and encourage hydration, adhering to your client's dietary restrictions.
6. Encourage exercise based on client capabilities/per doctor's orders.
7. Encourage independence with your client, allowing them to help with activities as much as possible.
8. Report to the office any **IMPORTANT** changes observed in your client or with any problems with your assignment.

### **EXAMPLES TO REPORT TO CARE MANAGER:**

- BRUISING
- SUDDEN MEMORY LOSS
- SUDDEN SLURRED SPEECH
- WEIGHT LOSS/WEIGHT GAIN/SWELLING
- LOSS OF BALANCE
- SUDDEN MOOD CHANGES—COMBATIVENESS, DEPRESSION, ETC.
- SIGNS OF ABUSE OR NEGLECT
- CHANGES IN APPETITE OR THIRST
- ABSENCE OF NEEDED FOOD OR SUPPLIES NECESSARY FOR CLIENT'S CARE

## **HOUSEKEEPING & PHONE ETIQUETTE**

1. Perform light housekeeping duties as required by your client. Allowable chores are indicated below:
  - a. Dusting the furniture
  - b. Vacuuming (including moving light pieces of furniture)
  - c. Laundry
  - d. Change the bed linens
  - e. Clean glass surfaces such as windows, mirrors, glass-topped tables
  - f. Mop floors
  - g. Clean bathroom, kitchen
  - h. Remove trash, set cans out for pickup
  - i. Water plants

## TELEPHONE MANNERS

1. Answer the client's telephone in a proper manner. For example, "Mr. Smith's residence, Mary speaking."
2. Personal cell phone use, **INCLUDING TEXTING AND EMAILS** while you are on duty is **NOT** allowed, unless you are reporting an incident with the client or it is an emergency!!
3. **NEVER** use a cell phone while driving your client, even when **ASKED BY THE CLIENT!**
4. Do not discuss your client on the phone or give out any information on your client!

## MEALS AND BREAK PERIODS

1. Caregivers are responsible for providing their own meals, drinks, and snacks. Please do not consume any of the client's food or drink without client/family permission.
2. Meals and Breaks are considered "on-duty" and caregivers are paid during this time. For example, if you are scheduled to work an 8-hour shift, it is recommended that you try and schedule a 10-minute break in the first half of your shift, a half hour meal and meals when it does **NOT** inconvenience the client. **NEVER LEAVE THE PREMISES OF YOUR CLIENT.** If for any reason you are not able to take your breaks, please notify the office.

## 24 HOUR/LIVE-IN CAREGIVERS

1. All duties and job descriptions apply to all 24 hour/Live-in caregivers.
2. Caregivers will provide their own food while on duty, unless directed by the client or client's family. They may request that you eat your meals with them, if appropriate.
3. Do not use the client's laundry facilities for personal use. Laundering your clothing that you are wearing is permissible.
4. Do not leave any personal items at a client's home when off duty.
5. Do not have any family members or friends visit you while on duty.
6. Personal cell phones may be used **ONLY** while you are on break, unless you are reporting any emergency or incident to the office.
7. Please change the linens on the bed used for the next caregiver coming on duty.
8. Live-in caregivers are expected to have 5 hours of uninterrupted sleep and breaks, totaling 3 hours throughout the day. If you are not able to get the maximum hours of rest, you need to report this to the office. **PLEASE REMEMBER TO FILL OUT YOUR SLEEP/REST FORMS AND TURN THEM IN WITH YOUR TIMESHEETS!**

## CAREGIVER/SITTER PROTOCOLS FOR FACILITIES

- All caregivers need to report to the assisted living desk prior to starting duties.
- All caregivers need to report to the nurses' station PRIOR to taking any breaks and upon completion of duties. The nurses at the nursing station may want to sign your time sheet at the end of your shift.
- Caregivers need to wear appropriate clothing such as scrubs and closed-toe shoes at all times. Please wear your name badges.
- Caregivers need to limit the use of cell phones, especially when in the common area.
- Caregivers are **NOT** to use personal computers, tablets, or any electronic devices while on duty.

## CAREGIVER DUTIES

- Assist client with bathing and grooming as needed.
- Caregivers may provide exercise assistance to client as instructed.
- You must help client with ambulation.
- **DO NOT LEAVE CLIENT UNATTENDED!** If you need to go on a break, please inform nursing staff ahead of time.
- Encourage activities as client is able.
- Companionship—please be as conversational as needed.
- Assist client with toileting and personal hygiene.
- **ALWAYS KEEP THE CLIENT SAFE! THIS IS A PRIORITY!**
- **ALWAYS ALERT NURSING STAFF WITH ANY CLIENT CHANGES OR EMERGENCIES.**
- **DO NOT SLEEP WHILE ON DUTY! BRING ALONG AN ACTIVITY TO DO WHILE THE CLIENT SLEEPS.**

## EQUAL EMPLOYMENT OPPORTUNITY POLICY

Acclaim Homecare/Acclaim Professional is an equal opportunity employer. Its policies, procedures, and personal programs are administered without regard to race, color, religion, sex, national origin, citizenship, age, marital status, sexual orientation, gender identification, or disability. This policy applies to recruitment and placement, promotion, transfer, retention, pay, and benefits as well as to all other privileges, personnel programs, organization policies, and conditions of employment.

**ALL** schedule changes **MUST BE DONE THROUGH THE OFFICE**. Employees are paid and clients are invoiced from the submitted timesheets. All employees must report any changes in hours on the day of the schedule changes, **PRIOR** to the change.

## **PAY PERIODS**

Pay periods are bi-monthly, paid every 15<sup>th</sup> and end of each month. Timesheets **MUST** be submitted and received five (5) business days prior to the pay date. If you want automatic deposit into your bank account, please complete the proper forms and turn it into the office. **This is the preferable option.**

Checks are also available for pick up at the office. **Please call if you do not want your paychecks mailed. All checks not designated for deposit will be mailed at approximately 4:30PM on payday. Mail time and dependable mail services vary. If you do not receive a mailed paycheck, the office will issue a replacement check NO SOONER than 10 days after the original check was mailed. A stop payment fee will be deducted from the replacement check. Replacement checks must be picked up during office hours.**

## **BENEFITS**

- Automatic check deposit: Employees may request automatic paycheck deposit to their banks.
- Acclaim Homecare/Acclaim Professional provides Workers Compensation insurance, comprehensive general liability insurance and service bond coverage.
- Acclaim Homecare/Acclaim Professional pays and deducts for Social Security, Medicare, Federal, State, and local income taxes.
- Acclaim Homecare/Acclaim Professional contributes to the State and Federal Unemployment Insurance Fund.
- Acclaim Homecare/Acclaim Professional provides Health Insurance Benefits from CCHP and Kaiser Permanente where the company contributes 50% of the lowest plan available and deducts employee contribution bi-monthly.

## **STANDARDS OF CONDUCT ACCLAIM HOMECARE/ ACCLAIM PROFESSIONAL**

1. **Always be on time for duty!** If your client has a log book, be sure and record any pertinent information for your time with the client.
2. Wear your name badge every time you are on duty. Only remove it if your client requests it.
3. **All calls need to come through the office.** Clients and the client's families should provide contact numbers as necessary. **You should NOT contact clients when you are not on duty.** Any condition change should be directed to the Care Manager.
4. Your family members and friends are NOT allowed on your work site for liability insurance purposes as well as client confidentiality.
5. **Do not discuss personal business/problems with the client.**
6. Do not discuss company issues with the client, such as your pay rate, etc.
7. Dress neat and clean. Wear scrubs unless the client requests street clothing. Do not wear jeans, shorts or sweatpants. Always wear closed-toe shoes.
8. Always maintain a professional attitude and be kind and courteous. **YOU** are in the clients' home!
9. Call the office staff 24 hours in advance to cancel a daily job. Call the office staff 48 hours prior to cancelling a live-in job.
10. Speak with the staffing manager to update your availability for duty.
11. Leave the clients' home neat and clean.

12. **NO SMOKING ON THE JOB!**
13. Be sure and wear seat belts when transporting clients. Please check that your client is belted as well. **(Only employees with approved insurance coverage can transport clients.)**
14. **Do not attempt to lift a client that requires TOTAL lifting!** If your client has a change of condition and requires more lifting, notify the office immediately. In the event you are assigned a client who requires lifting or transfer, **DO NOT ATTEMPT THE LIFT OR TRANSFER** and call the office immediately for instructions.
15. Only use an electric shaver to shave a client. **NEVER CLIP OR CUT A CLIENT'S TOENAILS.**
16. Report any gifts to the office **IMMEDIATELY**. Never accept a gift unless it is cleared by the office. **NEVER** accept gifts of cash or a check from a client.
17. When shopping for a client, never accept a check made out to you from a client. If given cash, make sure the client receives all change and a receipt for purchases. **NEVER** purchase alcohol for a client.
18. **DO NOT REPORT TO WORK UNDER THE INFLUENCE OF ALCOHOL OR DRUGS!** Do not consume alcohol or drugs while on duty. These are grounds for **IMMEDIATE TERMINATION OF EMPLOYMENT** with Acclaim Homecare/ Acclaim Professional.
19. All employees are required to have a current TB test or a chest X-ray. TB Tests are valid for **TWO** years from issue date and X-rays are valid for **FOUR** years from issue date.
20. Do **NOT** use your client's phone for personal calls.
21. Ask the client before changing the television or radio station. Do not order any pay per view stations.
22. **DO NOT** rearrange client's furniture, kitchen, or personal belongings, without permission of the client or client's family.
23. **DO NOT** wear jewelry or perfume when on duty with a client. Keep your fingernails trimmed.
24. Do **NOT** use slang or foul language. Do not speak in your native language to the client or in front of the client while having conversations.
25. Maintain a calm and reassuring attitude in a crisis situation.
26. **DO NOT** act as a witness for legal documents for your client or their family.

**Note: The office needs to know of any changes in hours scheduled as soon as possible. If the client requests that you leave prior to your scheduled time, please call the office before you leave.**

### **EMPLOYMENT PROCEDURES**

- Call the office with **ANY** condition changes in your client!
- With any emergencies with the client or with personal emergencies.
- When you are going to be late for an assignment. You must speak with a staff person, **DO NOT LEAVE A VOICEMAIL!**
- Call the office with your schedule and availability.
- Call the office with any personal change of address or phone number.
- Call the office with any job-related injury!
- Call the office if the client wishes to give you a gift or gratuity.
- Call the office when you wish to terminate your employment. **TWO WEEKS'** notice is required.

### **EMERGENCIES**



**In any case of an Emergency, always call 911 immediately!** If your client is a HOSPICE patient, you will need to call the hospice office. If there are ANY questions as to whom you should call, please call the office!

## **TERMINABLE OFFENSES**

### **THE FOLLOWING OFFENSES ARE GROUNDS FOR IMMEDIATE TERMINATION FROM EMPLOYMENT:**

- **FAILURE TO CALL AND NOT REPORTING AT AN ASSIGNMENT!**
- Any form of abuse, neglect or any form of exploitation.
- Threatening or fighting with a co-worker.
- Stealing or being dishonest in any form, including falsifying a timesheet.
- Being convicted of a felony.
- Reporting to work under the influence of drugs or alcohol.
- Possession of a weapon on work premises.
- Sleeping on the job, which is considered willful abandonment of your duty and the client. (Unless permitted, i.e.: Live-in)
- Harassment or discrimination based on race, religion, gender, gender orientation or disability.
- Personal use of a cell phone (calls, texting, emails) while at the client's house or while driving the client, unless it is specified break time.
- Abandoning the client.
- Borrowing money or possessions from the client.
- Asking the client to purchase items for you.
- Violating company policies and protocols.
- Using the client's car for personal use.
- Leaving the client in care unattended.

**Note: Due to the nature of the business, a no call/no show to work will result in immediate termination as an abandonment of your duty and the client, and it is considered a voluntary quit.**

## **CONFIDENTIALITY**

The employee must respect the privacy of the client and the family served. It is imperative therefore that all communications between the client, the client's family, and the employee be strictly confidential. Do not contact or visit a former client without permission from the office. Do not discuss other clients in the presence of another client. Do not bring the client to your home or on your personal errands.

### **CAREGIVER ACKNOWLEDGEMENT**

**I, \_\_\_\_\_, acknowledge that I have received and reviewed the information pertaining to the policies and procedures of ACCLAIM HOMECARE, INC/ACCLAIM PROFESSIONAL HEALTHCARE, LLC.**

**By signing this form, I agree to uphold the policies and procedures while an employee of ACCLAIM HOMECARE, INC/ACCLAIM PROFESSIONAL HEALTHCARE, LLC**

**I acknowledge that I have received a copy of the POLICY AND PROCEDURE MANUAL. A copy of the signed receipt will be placed in my personnel file folder.**

**Employee (Please print name) \_\_\_\_\_**

**Employee Signature \_\_\_\_\_**

**Company Representative \_\_\_\_\_**

**Signature \_\_\_\_\_**

**Date \_\_\_\_\_**



## Direct Deposit Enrollment/Change Form\*

Company Name and/or Client Number \_\_\_\_\_

Employee/Worker Name \_\_\_\_\_ Employee/Worker Number \_\_\_\_\_

**Employee/Worker:** Retain a copy of this form for your records. Return the original to your employer/company.

**Employer/Company:** Please retain a copy of this document for your records.

### COMPLETE TO ENROLL / ADD / CHANGE BANK ACCOUNTS - PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY

Add new	Update existing account	Replace existing account	Last 4 digits of the existing account number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Type of Account	Checking	Savings	Account holder's Name:				
Routing/Transit Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Checking/Savings Account Number**	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Financial Institution ("Bank") Name							
I wish to deposit (check one): _____ % of Net      Specific Dollar Amount \$ _____ .00      Remainder of Net Pay							

Add new	Update existing account	Replace existing account	Last 4 digits of the existing account number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Type of Account	Checking	Savings	Account holder's Name:				
Routing/Transit Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Checking/Savings Account Number**	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Financial Institution ("Bank") Name							
I wish to deposit (check one): _____ % of Net      Specific Dollar Amount \$ _____ .00      Remainder of Net Pay							

Add new	Update existing account	Replace existing account	Last 4 digits of the existing account number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Type of Account	Checking	Savings	Account holder's Name:				
Routing/Transit Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Checking/Savings Account Number**	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Financial Institution ("Bank") Name							
I wish to deposit (check one): _____ % of Net      Specific Dollar Amount \$ _____ .00      Remainder of Net Pay							

### CONFIRMATION STATEMENT - PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY

I authorize my employer/company to deposit my earnings into the bank account(s) specified above and, if necessary, to electronically debit my account to correct erroneous entries. I certify my account(s) allow these transactions. Furthermore, I certify that the above listed account number accurately reflects my intended receiving account. I agree that direct deposit transactions I authorize comply with all applicable laws. My signature below indicates that I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer/company make direct deposits into the named account. I understand that this authorization will remain in full force and effect until I notify Company in writing that I wish to revoke my authorization. I understand that the Company requires at least 5 business days prior notice to cancel this authorization.

**Employee/Worker Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_  
MM/DD/YY

I confirm that the above named employee/worker has added or changed a bank account for direct deposit transactions processed by Paychex, Inc. I have reviewed the information provided and it is accurate to the best of my knowledge. My signature below indicates that I have the authority to execute this document on behalf of the Client.

**Employer/Company Representative Printed Name:** \_\_\_\_\_

**Employer/Company Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
MM/DD/YY

\* All fields are required except Employee/Worker Number.

\*\* Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.

**Note:** Digital or Electronic Signatures are not acceptable.

**Employee's Withholding Certificate****2022**

- ▶ **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.**

**Step 1:  
Enter  
Personal  
Information**

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ <b>Does your name match the name on your social security card?</b> If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> <b>Single</b> or <b>Married filing separately</b> <input type="checkbox"/> <b>Married filing jointly</b> or <b>Qualifying widow(er)</b> <input type="checkbox"/> <b>Head of household</b> (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](http://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](http://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)
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**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):

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

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

**Preparer and/or Translator Certification (check one):**

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

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

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



Employer Completes Next Page





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

**USCIS**  
**Form I-9**  
OMB No. 1615-0047  
Expires 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.")

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

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

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

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

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

<b>A. New Name (if applicable)</b>			<b>B. Date of Rehire (if applicable)</b>	
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
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