Employment Application for RN

Please Print

AN EQUAL OPPORTUNITY EMPLOYER

Name: ______________________ Social Security No: ______________

Address: ____

Home Phone #: ______________ Cell/Other Phone #: ______________

Fax #: ______________ E-mail: ______________________

Position(s) Applied for: ______________________ Desired Rate of Pay: __________

License/ Certificate No.: ______________ State: _____ Expiration Date: __________

Driver's License No.: ______________ State: _____ Expiration Date: __________

To qualify for employment, you must be either (a) a citizen of the United States of America or (b) a registered alien with government permission to work in this country. Do either statement (a) or (b) describe your status as a resident of this country? ☐ Yes ☐ No

Have you ever been fired or asked to resign? ☐ Yes ☐ No

Have you ever been convicted, fined (excluding minor traffic offenses), placed on probation, or given a suspended sentence in any court, including Medicare fraud? ☐ Yes ☐ No

EDUCATIONAL BACKGROUND

Name and address of colleges/schools attended: (starting with your most recent)	Dates Attended	Major Subject or Course	Degree of Certificate Received
	From: To:		
	From: To:		
	From: To:		
	From: To:		

EMERGENCY CONTACT

Name:	Address:	Phone No.:	Relationship:

REFERENCES

List three business/work references that are *not* related to you and are *not* previous supervisors. If not applicable, list three school or personal references who are *not* related to you.

Name:	Address (if known):	Title:	Telephone:	No. of Years Known:

EMPLOYMENT HISTORY (starting with your most recent)

Employer		Telephone No.	
Address	City	State	Zip Code
Job Title/ Responsibility		Duration of Employment From: To:	
Immediate Supervisor/Title	Salary/Wages	May we contact for reference? ☐ Yes ☐ No ☐ Later	
Employer		Telephone No.	
Address	City	State	Zip Code
Job Title/ Responsibility		Duration of Employment From: To:	
Immediate Supervisor/Title	Salary/Wages	May we contact for reference? ☐ Yes ☐ No ☐ Later	
Employer		Telephone No.	
Address	City	State	Zip Code
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Immediate Supervisor/Title	Salary/Wages	May we contact for reference? ☐ Yes ☐ No ☐ Later	
Employer		Telephone No.	
Address	City	State	Zip Code
Job Title/ Responsibility		Duration of Employment From: To:	
Immediate Supervisor/Title	Salary/Wages	May we contact for reference? ☐ Yes ☐ No ☐ Later	

APPLICANT STATEMENT

I certify that all information I have provided in order to apply for and secure work with this employer is true, complete, and correct. I understand that any offer of employment I receive may be contingent on passing a job-related physical examination, and/or satisfactory completion of a background examination.

I expressly authorize, without reservation, the employer, its representatives, employees, or agents to contact and obtain information from all references (personal and professional), employers, public agencies, licensing authorities, and educational institutions and to otherwise verify the accuracy of all information provided by me in this application, resume, or job interview. I hereby waive any and all rights and claims I may have regarding the employer, its agents, employees, or representatives, for seeking, gathering, and using truthful and non-defamatory information, in a lawful manner, in the employment process and all other persons, corporations, or organizations for furnishing such information about me.

I understand that this employer does not unlawfully discriminate in employment and no question on this application is used for the purpose of limiting or eliminating any applicant from consideration for employment on any basis prohibited by applicable local, state, or federal law.

I understand that this application remains current for only 30 days. At the conclusion of that time, if I have not heard from the employer and still wish to be considered for employment, it will be necessary for me to reapply and fill out a new application.

If I am hired, I understand that I am free to resign at any time, with or without cause and with or without prior notice, and the employer reserves the same right to terminate my employment at any time, with or without cause and with or without prior notice, except as may be required by law. This application does not constitute an agreement or contract for employment for any specified period or definite duration. I understand that no supervisor or representative of the employer is authorized to make any assurances to the contrary and that no implied oral or written agreements contrary to the foregoing express language are valid unless they are in writing and signed by the employer's president.

I also understand that if I am hired, I will be required to provide proof of identity and legal authorization to work in the United States and that federal immigration laws require me to complete an I-9 Form in this regard.

I understand that any information provided by me that is found to be false, incomplete, or misrepresented in any respect, will be sufficient cause to (i) eliminate me from further consideration for employment, or (ii) may result in my immediate discharge from the employer's service, whenever it is discovered.

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE APPLICANT STATEMENT

I certify that I have read, fully understand, and accept all terms of the foregoing Applicant Statement.

Signature of Applicant: ______________________________ Date: ______________

ART HOME HEALTH CARE, INC.

TELEPHONE REFERENCE CHECK

Applicant Name: ______________________________ SS#: ____________________

Position Applied For: ____________________ Date of Telephone Reference Check: __________

Reference Name: ___________________________ Position: ____________________

Employment Dates: from ______________________ to _________________________

Position: ____

Reason for Leaving: ____

Would You Rehire?: ☐ Yes ☐ No If "No," Please Explain: ______________________

Please rate the applicant on the following:

Attendance	☐ Poor	☐ Average	☐ Above Average
Cooperation	☐ Poor	☐ Average	☐ Above Average
Initiative	☐ Poor	☐ Average	☐ Above Average
Job Knowledge	☐ Poor	☐ Average	☐ Above Average
Communication Skills	☐ Poor	☐ Average	☐ Above Average

Does the applicant have any work habits or personality traits that may negatively affect his/her work?

____

____

____

Additional Comments: ____

____

____

Person Completing the Telephone Reference Check:

Name: ______________________________ Title: ______________________

ART HOME HEALTH CARE, INC.

TELEPHONE REFERENCE CHECK

Applicant Name: ______________________________ SS#: ____________________

Position Applied For: ____________________ Date of Telephone Reference Check: __________

Reference Name: ____________________________ Position: ____________________

Employment Dates: from ______________________ to ________________________

Position: ____

Reason for Leaving: ____

Would You Rehire?: ☐ Yes ☐ No If "No," Please Explain: ______________________

Please rate the applicant on the following:

Attendance	☐ Poor	☐ Average	☐ Above Average
Cooperation	☐ Poor	☐ Average	☐ Above Average
Initiative	☐ Poor	☐ Average	☐ Above Average
Job Knowledge	☐ Poor	☐ Average	☐ Above Average
Communication Skills	☐ Poor	☐ Average	☐ Above Average

Does the applicant have any work habits or personality traits that may negatively affect his/her work?

____

____

____

Additional Comments: ____

____

____

Person Completing the Telephone Reference Check:

Name: ______________________________ Title: ______________________

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

Reports To: *Clinical Supervisor*

JOB DESCRIPTION SUMMARY

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

ESSENTIAL JOB FUNCTIONS/ RESPONSIBILITIES

Patient Care

1. Completes an initial assessment of patient and family to determine home care needs. Provides a complete physical assessment and history of current and previous illness(es).

2. Regularly re-evaluates patient's nursing needs

3. Initiates the plan of care and makes necessary revisions as patient's status and needs change.

4. Uses health assessment data to determine nursing diagnosis.

5. Develops a care plan, which establishes goals based on nursing diagnosis and incorporates therapeutic, preventive, and rehabilitative nursing actions. Includes the patient and the family in the planning process.

6. Initiates appropriate preventive and rehabilitative nursing procedures. Administers medication and treatments as prescribed by the physician.

7. Counsels the patient and family in meeting nursing and other related needs.

8. Provides health care instructions to the patient as appropriate per assessment and plan of care.

9. Identifies discharge planning needs as part of the care plan development and implements prior to discharge of the patient.

10. Acts as Case Manager when assigned by Clinical Supervisor and assumes responsibility to coordinate patient care for assigned caseload.

Communication

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

2. Communicates with the physician regarding the patient's needs and reports any changes in the patient's condition; obtains/receives physician's orders as required.

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3. Communicates with the community health related persons to coordinate the care plan.

Additional Duties

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

POSITION QUALIFICATIONS

1. Registered nurse with current licensure to practice professional nursing in the state.
2. Graduate of National League for Nursing accredited school of nursing.
3. Maintains a current CPR certification.
4. Must be a licensed driver with an automobile that is insured in accordance with state or organization requirements and is in good working order.
5. Minimum six months of experience, at least one of which is in the area of public health or home care nursing is preferred.
6. Self-directed and able to work with minimal supervision.
7. Demonstrates excellent observation, problem solving, verbal, and written communication skills; nursing skills per competency checklist.
8. Shows ability to organize and prioritize workload independently.
9. Management experience not required. Responsible for supervision of home health aides.
10. Prolonged or considerable walking or standing. Able to lift, or transfer, patients. Able to lift supplies and equipment. Frequent reaching, stopping, bending, kneeling, or crouching. Visual acuity and hearing to perform required nursing skills.

Employee Signature _______________________ Date _______________

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ART HOME HEALTH CARE, INC.

STAFF ORIENTATION & TRAINING ON HIPAA PROGRAM

Course Objective:

All Agency staff will be educated and able to verbally acknowledge the importance of orientation and training on HIPAA Program. Agency staff will be familiar with privacy policies and procedures, use and disclosure, complaints and breaches, violation and penalties, adopted by the Agency.

Course Outline:

1. The definition and identification of protected health information.
2. The Notice of Privacy Practices from that is provided to all patients.
3. Using and disclosing protected health information for treatment, payment, and health care operations.
4. Obtaining authorization for use and disclosure of protected information for purposes other than payment treatment of health care operations.
5. Obtaining a signed acknowledgment of Agency's Notice of Privacy Practices and Patient Privacy Rights.
6. Procedure for handling suspected violations of privacy policies and procedures.
7. Penalties for violation of privacy policies and procedures.
8. Documentation required by the policies and procedures outlined.
9. Agency staff members will:
   - Receive a summary of the Agency's privacy policies and procedures.
   - Have an opportunity to review the policy and procedures of the Agency.

Attached Policies and Procedures

1. Notice of Privacy Practices
2. HIPAA Staff Roles and Responsibilities
3. Compliance and Sanctions
4. Staff Security and Confidentiality Agreement

Employee/ Contractor Name: ______________________________ Title: ____________

Please Print

Employee/ Contractor Signature: ______________________________ Date: ____________

ORIENTATION CHECKLIST

Employee Name: ____

________ 1. Introduction to Office Staff

________ 2. Service Agreement and Position Descriptions

________ 3. Documentation and Forms

________ 4. Agency Policies and Forms

________ 5. Personal Policies

________ 6. Illness and Injury Presentation Program

________ 7. Infection Control

________ 8. Function of Referral to Other Disciplines

________ 9. Title XXII, Chapter 6, and Medicare Conditions of Participation

________ 10. Reporting of Significant Changes in the Patient's Condition

________ 11. Case Conferences

________ 12. In-Service Education

________ 13. Quality Management Program

________ 14. Patient/ Staff and Agency Confidentiality

________ 15. Fire Safety/ Emergency Preparedness

Acknowledgment

1. *I have been oriented to the above.*
2. *I have received a copy of my position description.*
3. *I have completed orientation.*

Employee/ Contractor Signature: ______________________________ Date: ________________

Agency Representative Signature: ______________________________ Date: ________________

EMPLOYEE HEALTH EXAMINATION

(To be completed by the employee's physician)

I have examined (Mr./ Ms.) ____ who is applying for the position of: ______________________ and have found no condition that appears to prevent him/her from performing the duties of the position applied for, with the exception or possible exception of the following: _____________

____

____

I have found no indication of any condition which might represent a possible hazard to the health of the patients or other employees of this facility. He/she is free from communicable diseases.

EXAMINATION

Height: _______________ Weight: ______________ Blood Pressure: ______________ Pulse: ______________

Family History: Any significant illness in the family? If so, please state the illness and relationship.

Family Member	Illness	Relationship

PHYSICAL EXAMINATION

PPD Test: Negative Positive Mantoux: _________ Date Administered: _____________

Chest X-Ray (if indicated): Negative Positive Date Administered: _____________

Adenopathy: __________
Reflexes: __________
Eyes: __________
Hearing: __________
Nose: __________
Throat: __________
Tongue: __________
Teeth: __________
Abdomen: __________
Rectal: __________

Chest: Breath Sounds: __________
Heart Size: __________
Murmur: __________
Rhythm: __________
Arteries: __________

Resonance: ______________

Physician's Name: ________________________________ Physician's Phone No.: ______________________

Physician's Address: ____

Physician's Signature: ____ Date: ____________________

EMPLOYEE TUBERCULOSIS RISK SCREENING ASSESSMENT

SYMPTOMS

Cough (Non-productive)	☐ Yes	☐ No
Cough (Productive)	☐ Yes	☐ No
Significant Weight Loss	☐ Yes	☐ No
Night Sweats	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No
Persistent Fatigue	☐ Yes	☐ No
Persistent Weakness	☐ Yes	☐ No
Chills and Fever	☐ Yes	☐ No
Hemotysis	☐ Yes	☐ No

HIGH RISK GROUP

Health Care Worker	☐ Yes	☐ No
Recent Exposure to Active TB Case	☐ Yes	☐ No
History of Positive Chest X-Ray	☐ Yes	☐ No
Pneumonia within Past Six Months	☐ Yes	☐ No
Current Immunosuppressive Therapy	☐ Yes	☐ No
10% or Below Ideal Body Weight	☐ Yes	☐ No
Chronic Illness:		
Diabetes Mellitus	☐ Yes	☐ No
End Stage Renal Disease	☐ Yes	☐ No
Silicosis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No

Three (3) or more "Yes" responses require physician verification of the following:

- Employee is free from health conditions which would interfere with the employee's ability to perform assigned duties
- Employee is free from symptoms of infectious disease

______________________________ Employee Signature

______________________________ Date

ART HOME HEALTH CARE, INC.

PHYSICAL EXAM, TB, XRAY, FLU VACCINE ACKNOWLEDGEMENT RECEIPT

1. Physical Exam must be done within 6 months before hiring date and no more than 15 days after hiring date.
2. For positive TB, you need X-Ray which is valid for 2 years
3. If TB was done more than 6 months before your hiring date, just fill out the questionnaire titles "Employee Tuberculosis Risk Screening Assessment."
4. Influenza Vaccination Waiver must be signed. Flu vaccines must be done between September and March annually. If you have been vaccinated, you must provide proof.

This is to acknowledge that I have read and understand the above terms and conditions.

Employee/ Contractor Name: ______________________________ Title: ______________
Please Print

Employee/ Contractor Signature: ______________________________ Date: ______________

ART HOME HEALTH CARE, INC.

INFLUENZA VACCINATION WAIVER

Employee Name/ Title: ____

DECLINATION STATEMENT:

I understand that due to my occupation I am at a higher risk to be exposed to influenza virus.

I, the undersigned, have been offered the opportunity to receive influenza vaccination free of charge or be reimbursed for it annually.

I have been instructed about influenza vaccine, non-vaccine control and prevention measures, the diagnosis, transmission, and impact of influenza.

I will be wearing protective mask during the skilled visit to the patient's house in order to prevent spreading of the infection in case patient, members of the patient's household, or myself were exposed to the flu viruses.

I DECLINE THE OPTION OF BEING VACCINATED AT THIS TIME:

☐ I have already been vaccinated

☐ I do not wish to be vaccinated due to:

- ___ severe allergies to chicken eggs
- ___ severe reaction to an influenza vaccination
- ___ moderate to severe illness with fever
- ___ history of Guillian-Barre Syndrome
- ___ religious preference
- ___ opposed to vaccination
- ___ other medical contraindications/ personal choice

_______________________________________ _______________________

Employee Signature Date

ART HOME HEALTH CARE, INC.

HEPATITIS B VACCINATION WAIVER

Employee Name/ Title: ____

DECLINATION STATEMENT:

I understand that due to my occupational exposure to blood or other potentially infections materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection.

I, the undersigned, have been offered the opportunity to receive a Hepatitis B Vaccination free of charge as an employment benefit provided by the agency.

I DECLINE THIS OPTION:

- ☐ I have already been vaccinated against the Hepatitis B Virus.
- ☐ I do not wish to be vaccinated.

I understand I may rescind this waiver at any time during my employment, and at that time, exercise my right to receive the Hepatitis B vaccination series at no charge to me.

____ ______________________

Employee Signature Date

SKILL AND EXPERIENCE INVENTORY FOR THE SKILLED NURSE/LVN

Name ____________________ Position ____________________

Date of Hire ____________________ Date Completed by Employee ____________________

Check One: ☐ Orientation ☐ Annual Competency ☐ Other ____________________

Directions: Circle the number that best describes your experience with each particular skill
1 = Very Experienced 2 = Somewhat experienced 3 = Not experienced NA = Not Applicable
♠= Profiency Demonstration Required ♣= Follow guidelines in Care Staff Competency Policy

No.	Skill	Registered Nurse	Licensed Practical Nurse	Date Observed or Reviewed	Signature of Evaluator	Comments
1.	Waived Laboratory test: Glucometer					
	a. Verbalizes purpose of test ♠	1 2 3 NA	1 2 3 NA			
	b. Specimen Collection ♠	1 2 3 NA	1 2 3 NA			
	c. Instrument Calibration ♠	1 2 3 NA	1 2 3 NA			
	d. Quality control mechanisms♠	1 2 3 NA	1 2 3 NA			
	e. Test correctly performed and interpreted ♠	1 2 3 NA	1 2 3 NA			
3.	Pulmonary System:					
	a. General exam and auscultation	1 2 3 NA	1 2 3 NA			
	b. Use and care of oxygen	1 2 3 NA	1 2 3 NA			
	c. Tracheostomy care	1 2 3 NA	1 2 3 NA			
	d. Nebulizer treatment	1 2 3 NA	1 2 3 NA			
	e. Oral/nasal suctioning	1 2 3 NA	1 2 3 NA			
	f. Breathing exercises/incentive spirometry	1 2 3 NA	1 2 3 NA			
	g. Percussion	1 2 3 NA	1 2 3 NA			
	h. Ventilator	1 2 3 NA	1 2 3 NA			
	i. Pulse Oximeter	1 2 3 NA	1 2 3 NA			

No.	Skill	Registered Nurse	Licensed Practical Nurse	Date Observed or Reviewed	Signature of Evaluator	Comments
	j. Apnea Monitor	1 2 3 NA	1 2 3 NA			
4.	Cardiovascular System:					
	a. General exam and auscultation	1 2 3 NA	1 2 3 NA			
	b. Pulses (apical, radial, femoral, pedal, popliteal)	1 2 3 NA	1 2 3 NA			
	c. Edema assessment	1 2 3 NA	1 2 3 NA			
	d. Supine and orthostatic blood pressure	1 2 3 NA	1 2 3 NA			
	e. Nitroglycerine use	1 2 3 NA	1 2 3 NA			
	f. Energy conservation techniques	1 2 3 NA	1 2 3 NA			
5.	Neurologic					
	a. General exam including LOC and grasps	1 2 3 NA	1 2 3 NA			
	b. Aphasia care	1 2 3 NA	1 2 3 NA			
	c. Seizure precautions	1 2 3 NA	1 2 3 NA			
	d. Cognition assessment	1 2 3 NA	1 2 3 NA			
6.	Gastrointestinal					
	a. General exam and auscultation	1 2 3 NA	1 2 3 NA			
	b. Abdominal Girth	1 2 3 NA	1 2 3 NA			
	c. Ostomy care	1 2 3 NA	1 2 3 NA			
	d. Ostomy irrigation	1 2 3 NA	1 2 3 NA			
	e. GT care and feedings	1 2 3 NA	1 2 3 NA			
	f. JT care and feedings	1 2 3 NA	1 2 3 NA			
	g. Dysphagia precautions	1 2 3 NA	1 2 3 NA			
	h. Impaction removal	1 2 3 NA	1 2 3 NA			
	i. Enema Administration	1 2 3 NA	1 2 3 NA			
	j. Ileostomy	1 2 3 NA	1 2 3 NA			
	k. Bowel training	1 2 3 NA	1 2 3 NA			
7.	Integumentary System:					
	a. General Exam	1 2 3 NA	1 2 3 NA			
	b. Sterile dressing change	1 2 3 NA	1 2 3 NA			

No.	Skill	Registered Nurse	Licensed Practical Nurse	Date Observed or Reviewed	Signature of Evaluator	Comments
	c. Wet to dry dressing	1 2 3 NA	1 2 3 NA			
	d. Suture/staple removal	1 2 3 NA	1 2 3 NA			
	e. Decubitus care	1 2 3 NA	1 2 3 NA			
	f. Assessment and staging	1 2 3 NA	1 2 3 NA			
	g. Various wound treatments including transparent films and Duoderm	1 2 3 NA	1 2 3 NA			
	h. Documentation of a wound	1 2 3 NA	1 2 3 NA			
8.	Genitourinary System:					
	a. General Exam	1 2 3 NA	1 2 3 NA			
	b. Male urinary catheterization, care and patient education	1 2 3 NA	1 2 3 NA			
	c. Female urinary catheterization, care and patient education	1 2 3 NA	1 2 3 NA			
	d. Condom catheter	1 2 3 NA	1 2 3 NA			
	e. Incontinence care	1 2 3 NA	1 2 3 NA			
	f. Bladder training	1 2 3 NA	1 2 3 NA			
9.	Musculoskeletal System:					
	a. General exam	1 2 3 NA	1 2 3 NA			
	b. ROM (active and passive)	1 2 3 NA	1 2 3 NA			
	c. TED hose	1 2 3 NA	1 2 3 NA			
	d. Total knee replacement care	1 2 3 NA	1 2 3 NA			
	e. Total hip replacement care	1 2 3 NA	1 2 3 NA			
	f. Cast assessment and care	1 2 3 NA	1 2 3 NA			
	g. Walker use instruction	1 2 3 NA	1 2 3 NA			
	h. Wheelchair use instruction	1 2 3 NA	1 2 3 NA			
	i. Hoyer lift use	1 2 3 NA	1 2 3 NA			
10.	Metabolic System:					
	a. General exam	1 2 3 NA	1 2 3 NA			
	b. Insulin types and teaching	1 2 3 NA	1 2 3 NA			
	c. Glucometer instruction	1 2 3 NA	1 2 3 NA			
	d. Diet, exercise and sick day	1 2 3 NA	1 2 3 NA			

No.	Skill	Registered Nurse	Licensed Practical Nurse	Date Observed or Reviewed	Signature of Evaluator	Comments
	instruction of the diabetic					
	c. S/S of hypoglycemia and hyperglycemia	1 2 3 NA	1 2 3 NA			
	f. Foot care and skin care	1 2 3 NA	1 2 3 NA			
11.	Medications					
	a. Oral Administration	1 2 3 NA	1 2 3 NA			
	b. Rectal Administration	1 2 3 NA	1 2 3 NA			
	c. IM administration	1 2 3 NA	1 2 3 NA			
	d. Subcutaneous administration	1 2 3 NA	1 2 3 NA			
	e. Z-track	1 2 3 NA	1 2 3 NA			
	f. Peripheral IV therapy ✱	1 2 3 NA				
	g. Hickman-Broviacs ✱	1 2 3 NA				
	h. Port-a-caths ✱	1 2 3 NA				
	i. PICC lines ✱	1 2 3 NA				
	j. TPN ✱	1 2 3 NA				
	k. Enteral feedings	1 2 3 NA				
	l. Chemotherapy ✱	1 2 3 NA				
	m. IV pumps	1 2 3 NA				
	n. Parenteral pain management	1 2 3 NA				
	o. Parenteral hydration	1 2 3 NA				
	p. Parenteral Dobutamine	1 2 3 NA				
12.	Venipuncture for lab draws	1 2 3 NA	1 2 3 NA			
13	Pain Assessment	1 2 3 NA	1 2 3 NA			
	Pain Management	1 2 3 NA	1 2 3 NA			
	Equigesic	1 2 3 NA	1 2 3 NA			
	Non-Medical Pain Interventions	1 2 3 NA	1 2 3 NA			
	Documentation of Pain	1 2 3 NA	1 2 3 NA			

PERFORMANCE EVALUATION

Job Title/Position: *Registered Nurse*
Date:
Reviewer: [ ] Annual [ ] 90 Day [ ] Other **Page 1**

A. Patient Care Responsibilities

		Rating
	Patient Care	
1.	Completes an initial assessment of patient and family to determine home care needs. Provides a complete physical assessment and history of current and previous illness(es).	1 2 3 4
2.	Regularly re-evaluates patient nursing needs.	1 2 3 4
3.	Initiates the plan of care and makes necessary revisions as patient status and needs change.	1 2 3 4
4.	Uses health assessment data to determine nursing diagnosis.	1 2 3 4
5.	Develops a care plan that establishes goals, based on nursing diagnosis and incorporates therapeutic, preventive, and rehabilitative nursing actions. Includes the patient and the family in the planning process.	1 2 3 4
6.	Initiates appropriate preventive and rehabilitative nursing procedures. Administers medications and treatments as prescribed by the physician.	1 2 3 4
7.	Counsels the patient and family in meeting nursing and related needs.	1 2 3 4
8.	Provides health care instructions to the patient as appropriate per assessment and plan.	1 2 3 4
9.	Identifies discharge planning needs as part of the care plan development and implements prior to discharge of the patient.	1 2 3 4
	Communication	
1.	Prepares clinical notes and updates the primary physician when necessary and at least every sixty days.	1 2 3 4
2.	Communicates with the physician regarding the patient's needs and reports any changes in the patient's condition; obtains/receives physician's orders as required.	1 2 3 4
3.	Communicates with community health related persons to coordinate the care plan.	1 2 3 4
	Additional Duties	
1.	Participates in on-call duties as defined by the on-call policy.	1 2 3 4
2.	Ensures that arrangements for equipment and other necessary items and services are available.	1 2 3 4
3.	Instructs, supervises and evaluates home health aide care provided every two (2) weeks.	1 2 3 4

Targeted Goals For Next Review Cycle:

____

____

Comments:

____

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Reviewer: ______________________________ Date: __________

Name of Personnel: ______________________________ Date: __________

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PERFORMANCE EVALUATION

Job Title/Position: *Registered Nurse*
Date:
Reviewer: [ ] Annual [ ] 90 Day [ ] Other **Page 2**

Key: 4 - Superior Performance [illegible]

B. Organizational Responsibilities	Rating
1. Adheres to patient assignments as appropriate and reviews plan of care on an ongoing basis to maintain coordination of services.	1 2 3 4
2. Maintains an acceptable work record. ______ Days Tardy ______ Days Absent	1 2 3 4
3. Informs coordinator of availability weekly.	1 2 3 4
4. Reviews policy manual when patient care procedures and organization personnel procedures need clarification.	1 2 3 4
5. Supervises LPNs and home health aides/nursing assistants for care provided.	1 2 3 4
6. Accepts responsibility for behavior and activity.	1 2 3 4
7. Is respectful of individuals rights in interacting with patients, families/caregivers and coworkers.	1 2 3 4
8. Follows organization guidelines in practice of: (a) Infection Control (b) Fire/Safety (c) Patient Care Standards	1 2 3 4
9. Displays appropriate management of equipment and supplies (acquisition to distribution).	1 2 3 4
10. Participates in organization quality activities to improve organizational performance.	1 2 3 4
11. Interacts collaboratively with all team members.	1 2 3 4

Targeted Goals For Next Review Cycle:

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Comments:

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Reviewer: ____________________________ Date: __________

Name of Personnel: ________________________ Date: __________

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PERFORMANCE EVALUATION

Job Title/Position: *Registered Nurse*
Date:
Reviewer: [ ] Annual [ ] 90 Day [ ] Other **Page 3**

[illegible]

C. Educational/Inservice Responsibilities	Rating
1. Completes CPR program annually.	1 2 3 4
2. Fire/Safety, Emergency Management, Infection Control, Ethics, and Performance Improvement programs are attended annually.	1 2 3 4
3. Attends inservices quarterly and identifies self-learning goals.	1 2 3 4
4. Completes annual competency skills checklist.	1 2 3 4

Targeted Goals For Next Review Cycle:

____

Comments:

____

Reviewer: ____________________ Date: ________

Name of Personnel: ____________________ Date: ________

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SKILLED NURSE EXAMINATION FOR GLUCOSE TESTING USING GLUCOMETER

(circle the best answer)

1. **Quality Control must be run:**
   a. Every 24 hours of use
   b. When the meter is dropped
   c. When new lot # of strips is open
   d. All of the above

2. **You will need ready before begin testing :**
   a. Meter, Test strips, Lancets
   b. Alcohol preps
   c. Meter only
   d. All of the above

3. **Low and High control ranges values can be found on the bottom of the strip box.**
   a. True
   b. False

4. **Apply control solution to the strips directly from bottle.**
   a. True
   b. False

5. **If patient test results is below 50 mg/dL, or above 250 mg/dL on meter display- do not call MD or healthcare professional immediately.**
   a. True
   b. False

Printed Name ______________________________

Signature ______________________________

Date ______________________________

HAND HYGIENE MONITORING/ SUPERVISION

Staff Member Name: ____________________________ Date: ________________________

Tasks	#of opportunities observed	# of met opportunities
Wash or use hand gel upon initial entry into bag and before touching patient		
Wash or use hand gel before putting on gloves/ and after gloves removed		
Wash or use hand gel during patient's care, between patient tasks, after direct contact with patient		
Wash or use hand gel before reentering the clinical bag, and before using the computer		
Wash or use hand gel when hands become contaminated (touching outside objects)		
Wash or use hand gel after coming in contact with the source likely to be contaminated with pathogens		
Wash hands with liquid soap and water for 20 sec.		
Using hand gel and rubbing hands for 20 sec if no running water is available		
Wash or use hand gel before leaving the patient's home		
Using paper towels to dry hands		
Using paper towel to turn off the faucet after hand washing		
Nails are short, well maintained		

Numerator - # opportunities met, Denominator - # opportunities observed

Evaluator Name: ____

Signature: ____

Registered Nurse Pre-Employment Examination

(CIRCLE THE BEST ANSWER)

1. **Before giving an adult patient prescribed daily dose of digoxin, the nurse finds the patient's apical pulse in 54. Before administration of medication:**

   a. re-check order, then give the dose
   b. hold medication, notify the physician
   c. break the tablet in half, give half dose
   d. give the medication in divided doses

2. **The patient's blood sugar level registered at 45 mg/dl per glucometer reading. Based on the reading, the patient should have the following symptoms:**

   a. tachycardia
   b. pallor, perspiration
   c. twitching, unsteady gait
   d. confusion, erratic behavior
   e. all of the above

3. **Universal Precautions include all <u>EXCEPT</u>:**

   a. use of goggles to perform daily bath
   b. use gloves to start peripheral I.V.
   c. use of gown, gloves to clean patient's bloody diarrhea
   d. disposal of used syringes without recapping needles

4. **While eating, the patient starts to choke and cough. The first thing you do is:**

   a. give an abdominal thrust
   b. give four back blows
   c. check apical pulse
   d. ask, "can you speak?"

5. **In trach suctioning, you must remember the importance of:**

   a. inserting catheter until resistance is met
   b. initiating suctioning as catheter is gently withdrawn
   c. untying neck tapes when cleansing the stoma
   d. removing the inner cannula prior to suctioning

6. **A bedridden patient, taking oral antibiotics now has RLL pneumonia. Which action is <u>NOT</u> appropriate?**

   a. chest percussion and postural drainage q 4 hours
   b. auscultate breath sounds q 2-4 hours
   c. administer expectorants as ordered
   d. encourage low fluid intake to prevent fluid overload

7. **Which of the following would be safety hazards?**

   a. scattered throw rugs on the floor
   b. overload electrical outlets
   c. frayed electrical wiring
   d. all of the above

8. **For a small grease fire in the kitchen, you would <u>NOT</u>:**

   a. move the patient out of the house
   b. call "911"
   c. pour water on flames
   d. use baking soda or fire extinguisher if fire is contained

9. **Otto was injured in an accident and discharged in a body cast. Otto should have his position changed at least:**

   a. once a shift
   b. every two hours
   c. twice a day
   d. at bath time and bed time

10. **Patient with bruises on her arms states her son is abusive. Which of the following in <u>NOT</u> appropriate?**

    a. notifying your supervisor
    b. confronting son with the information
    c. notification of MD, MSW and protective services
    d. all of the above

11. A comatose patient in your care receives all medication via NG tube. Caregiver pours meds directly from bottle into the tube. Your family education would include:

a. always check tube for placement first, otherwise it's OK
b. check tube for placement and measure dose every time
c. measure correct dosage, but no need to check placement
d. all of the above

12. You're asked to perform an in-and-out cath on a patient who often has it done at home. Without orders, you would:

a. perform the procedure since it's routinely done by wife
b. refuse to do the procedure without doctor's orders
c. do the procedure, then call for a doctor's order
d. call MD to explain, get orders, then do

13. Signs and symptoms of digitalis toxicity are:

a. anorexia and nausea
b. generalized muscle weakness and hallucination
c. arrhythmias and hypotension
d. all of the above

14. The following about AIDS and blood are <u>FALSE</u> except:

a. AIDS can be contracted by giving blood
b. risk of AIDS from a blood transfusion is now low
c. blood infected with HIV is treated at very high temps
d. all of the above

15. A patient receiving oxygen @ 2LPM via nasal prongs complains of "air hunger." Which action is <u>NOT</u> appropriate?

a. increase oxygen to 10LPM
b. elevate HOB to 90 degrees
c. assist patient to do "purse-lipped" breathing
d. administer IPPB as ordered

16. When manually ventilating a patient with an ambu bag due to ventilator failure, adequate ventilation is determined by:

a. patient's color
b. normal rise and fall of the chest
c. adequate air exchange on auscultation
d. all of the above

17. Which of the following does NOT indicate wound infection?

a. serous drainage from Penrose drain
b. low-grade temperature
c. erythema around incisional site
d. tenderness in the incisional area

18. In teaching safe self-administration of Prednisone, you include all of the following <u>EXCEPT</u>:

a. "you may need to increase your salt intake"
b. "protect yourself from infections"
c. "take the medication with meals or snack"
d. "never stop the medication abruptly"

19. MD orders 3000u of drug dispensed in 5000u/ml:

a. patient should receive 0.3ml
b. patient should receive 0.4ml
c. patient should receive 0.6ml
d. patient should receive 0.8ml

20. Patient with difficulty swallowing receives 1.25mg of Elixir. On hand is 4ml = 0.625mg. What do you give?

a. 8ml
b. 80ml
c. 0.8ml
d. 1ml

21. Iron preparations should be administered:

a. at bedtime
b. before breakfast
c. with meals
d. anytime

22. For the patient receiving 40u regular insulin at 7:30 am, the most likely time for an insulin reaction is:

a. by 8:00 am
b. at 4:00 pm
c. during the night
d. around 11:00 am

23. The HIV virus is spread by all of the following <u>EXCEPT</u>:

a. hugging and kissing on the cheek
b. sexual activity
c. receipt of blood/blood products
d. sharing needles/syringes

24. To prevent thrombosis after an MI, the MD orders:

a. coumadin
b. protamine
c. vitamin K
d. a and b

25. When taking Lasix, patient is encouraged to increase:

a. fluids
b. sodium
c. calcium
d. potassium

26. Nitroglycerin (NTG) is most commonly used for:

a. aches in lower back
b. pains in the chest
c. shortness of breath
d. edema of hands and feet

27. A common side effect of Codeine is:

a. diarrhea
b. constipation
c. slurred speech
d. increased pain

28. For the patient with dyspnea, the most comfortable position would be:

a. Sims left lateral
b. Fowlers
c. Trendelenberg
d. supine

29. Which of the following is said to have a vital role in the healing process?

a. vitamin A
b. vitamin B-12
c. vitamin C
d. vitamin D

30. Mr. S arrived in ER from work with chest pain, SOB, nausea and perspiring profusely. MS ¼ gr IV was ordered for the purpose of:

a. relieving the nausea
b. relieving the chest pain
c. increasing the circulation
d. relieving the SOB

31. The comatose patient must receive frequent oral care. It is important to consider one of the following:

a. help patient rinse mouth frequently with mouth wash
b. brush teeth once a day to prevent halitosis
c. clean teeth with padded tongue blade and peroxide
d. lubricate lips to prevent cracking

32. The patient in Trendelenberg is lying on his back with:

a. knees slightly flexed
b. knees and thighs flexed
c. feet lower than his head
d. head lower than his feet

33. Which would <u>NOT</u> be considered clear liquid?

a. orange juice
b. ginger ale
c. tea
d. sweetened black coffee

34. **For an accurate BP reading, it is important that the patient:**

a. has received no stimulants within the past hour
b. is lying down
c. has a well-supported arm during the procedure
d. has cuff inflated for one minute before it's deflated

35. **It is recommended that an enema not be held higher:**

a. than 18 inches above patient's buttocks
b. than 18 inches above the floor
c. than 6 inches above the patient's buttocks
d. than 36 inches above the patient's buttocks

36. **A terminal CA patient is not aware of his prognosis. Who decides if he is to be told?**

a. the doctor and the patient's wife
b. the nursing staff
c. the doctor and the administrator
d. the patient's friends and relatives

37. **When collecting a "midstream urine," which of the following would NOT apply?**

a. void directly into the sterile specimen cup
b. discard the first 30 ml of urine
c. stop the collection of urine before bladder empties
d. clean the meatus after specimen is obtained

38. **Ms. L reports a warm, reddened area on the back of leg:**

a. elevate legs and tell her to stay in bed
b. rub legs to start circulation
c. encourage ambulation
d. take pedal pulses, order bed rest, call physician

39. **After abdominal surgery, Mrs. Thompson developed thrombophlebitis. Which of the following is a sign?**

a. severe chest pain on extension of extremity
b. pitting edema of lower extremity
c. intermittent claudication
d. warm, tender area on leg

40. **Coumadin is ordered for Mrs. Thompson. Which drug is ordered for Coumadin overdose?**

a. Imferon
b. Heparin
c. Aquamephyton
d. Protamine Zinc

41. **Which of the following tests would most likely be ordered for the patient receiving Coumadin?**

a. prothrombin time
b. clotting time (Lee White)
c. bleeding time
d. sedimentation rate (ESR)

42. **A depressed, suicidal patient is notably more cheerful. The morning activities are done cheerfully. The nurse:**

a. concludes the psychotherapy is a modern miracle
b. holds morning medications
c. observes very closely because behavior may indicate patient is no longer in conflict and his made the decision to commit suicide

43. **Recovering from dehydration and malnutrition, Mr. Sums now spends significant time berating himself for drinking and making comments about care. Nursing responses should include:**

a. allowing patient to express feeling of regret
b. explanation that drinking is disgusting to most people
c. explanation that alcoholics have addictive personalities

44. **The cancer patient's ability to fight infection is determined by:**

a. the white blood cell count
b. the granulocyte count
c. the presence or absence of fever
d. the patient's subjective complaints

45. The safest technique for opening the airway in most cases is:

a. modified jaw thrust maneuver
b. turn the victims head to one side
c. perform chest percussions
d. wipe out the victim's mouth and throat

46. The most common cause of airway obstruction is:

a. food
b. mucus
c. dentures
d. tongue

47. Gastric irritation is a side effect of a long-term steroid therapy. An effort toward prevention would be:

a. Valium for sedation
b. Aspirin for relief of abdominal discomfort
c. use of antacids
d. give medication with meal

48. Congestive heart failure is a condition in which the heart:

a. fails to remain pliable
b. remains small than normal
c. is unable to meet fluid demands of the body
d. fails to beat regularly

49. Elderly people may be prone to constipation because:

a. of the loss of voluntary control of defecation
b. dentures prevent them from eating food high in bulk and fiber
c. an atonic colon and weakness of abdominal muscles
d. the colon looses the ability to secrete fluids

50. AMI is characterized by:

a. pain in the muscles of the calf
b. pressure like pain
c. substernal pain that dose not go away
d. B+C

Printed Name:

____

Signature:

____

Date:

____

ART HOME HEALTH CARE, INC.

CONFIDENTIALITY STATEMENT

I understand that in the performance of my duties as an employee of this Agency, I may have access to, and may be involved in, the processing of patient information. I understand that I am obligated to maintain the confidentiality of this patient information at all times, both at work and off duty.

- ☐ I understand that violation of these confidentiality considerations may result in disciplinary action, including termination. I further understand that I could be subjected to legal action.
- ☐ I understand that I am not to interpret, discuss, or otherwise relay medical or personal information about the patients, unless necessary, during the course of fulfilling my job duties.
- ☐ I certify by my signature that I have participated in orientation and training concerning the privacy and confidentiality considerations of member information.

Employee/ Contractor Signature: ______________________________ Date: _______________

ART HOME HEALTH CARE, INC.

CONFLICT OF INTEREST STATEMENT

I understand that in the course of my contractual relationship with **ART HOME HEALTH CARE, INC.** (the "Agency") or any of its affiliates, subsidiaries, successors, or assigns, I may learn, handle, or process information, either written or verbal, which is considered confidential and/or for restricted (e.g., "need to know") distribution.

This information includes, but is not limited to:

a) Patient information of any type
b) Physician information of any type
c) Personnel information of any type
d) Any information which would directly or indirectly benefit a competitor, including, but not limited to, information regarding finances (past, present, or future), the operations of the company, patents pending, future organizational or operational plans, referral sources, patient lists, or any similar information.

I understand that disclosure of information about patients and staff (both contractor and medical) is strictly regulated by law. I further understand the privacy rights of these individuals, violation of which could result in a claim for legal damages. I further understand that the Agency views discloses of any information regarding confidential matters regarding its operations as a violation of the duty of loyalty of a contractor/ employee and a conflict of interest.

I further understand that the failure to maintain the confidentiality of information would be considered a serious breach of my contractual relationship responsibilitics, which could result in substantial disciplinary action, including, but not limited to, immediate termination of the contract.

I understand that the obligation to preserve confidentiality of information continues in full force and effect notwithstanding termination (whether voluntary or involuntary) of my contractual relationship with the Agency.

Employee/ Contractor Name: ______________________________ Title: ______________
Please Print

Employee/ Contractor Signature: ______________________________ Date: ______________

ART HOME HEALTH CARE, INC.

CODE OF CONDUCT

To aid Agency in attainment of its mission of providing quality health care to the public in the home care, standards of conduct have been developed and approved by the Board of Directors and the agency's leadership. It is therefore expected that all employees and contracted individuals will thoroughly understand and conduct themselves according to the tenets stated below:

1. The employee will complete scheduled visits and assignments on a timely basis.
2. The employee will complete required classes, orientation, and educational requirements to maintain current licensure and compliance with the Agency's policy.
3. The employee will submit accurate records of employment, applications, and time cards/ route sheets.
4. The employee will conduct his/herself in a professional manner in all interactions with supervisors, peers, and clients. Licensed and certified employees will hold to the standards of their accrediting board.
5. The employee will present themselves in a professional manner by proper grooming as well as appropriate attire.
6. The employee will respect the right of the property of the Agency, other employees, and patients.
7. The employee will refrain from excessive or unexcused absences.
8. The employee will not engage in any of the following:
    a. Negligence
    b. Possession or being under the influence of alcohol or illegal substances
    c. Possessions of weapons while on duty
9. The employee will be aware of and practice safety policies and procedures.
10. The employee will perform his/her duties as stipulated in the criteria-based job descriptions.
11. The employee will be aware and adhere to the fraud and abuse laws as stated in the Medicare Act.
12. The employee will refrain from use of prejudicial or offensive language.

The type of disciplinary action which may be taken in response to violation of this Code of Conduct will be determined on an individual basis to include, but may not be limited to, the following: reporting incidents to licensing agencies where applicable, oral warning, written warning, suspension without pay, demotion, probation, or termination. Violation of the Medicare Fraud and Abuse Laws may result in fines of up to $25,000 and 5 years imprisonment.

I have read and agreed to comply with the above Code of Conduct.

____________________	____________________	____________
Printed Name	Signature	Date

ART HOME HEALTH CARE, INC.

CHILD ABUSE REPORTING RESPONSIBILITY

Section 11166 of the Penal Code requires that any childcare custodian, health practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

"Child Care Custodian" includes:

- Teachers, instructional aides, a teacher's aide, or a teacher's assistant employed by any public or private school, who has been trained in the duties imposed by this article if the school district has so warranted to the State Department of Education
- A classified employee of any public school who has been trained in the duties imposed by this article, if the school has so warranted to the State of Department of Education
- Administrative officers, supervisors of child welfare and attendance, or certified pupil personnel employees of any public or private youth centers, youth recreations programs and youth organizations
- Administrators or employees of public or private organizations whose duties require direct contact and supervision of children and who have been trained in the duties imposed by this article, licenses, administrators, and employees of licensed community care of child day care facilities
- Head start teachers
- Licensing worker or licensing evaluators
- Public assistance workers, employees of a child care institution including, but not limited to, foster parents, group home personnel and personnel of residential care facilities
- Social workers, probation officers or parole officers' employees of a school district police or security department; or any person who is an administrator of presenter of, or counselor in a child abuse prevention program in any public or private school

"Health Practitioner" includes:

- Physicians and surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrist, chiropractors, licensed nurses, dental hygienists, optometrists, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business & Professional code
- Marriage, family, and child counselors
- Emergency medical technicians I or II, paramedics, or other persons certified pursuant to Division 25 (commencing with Section 1797) of the Health & Safety code
- Psychological assistants registered pursuant to Section 2913 of the Business & Professional code
- Marriage, family, and child counselor trainee, as defined in subdivision © of Section 4980.03 of the Business & Professional Code
- State or county public health employees who treat minors for venereal disease of any other condition
- Coroners
- Paramedics and religious practitioners who diagnose, examine, or treat children

I hereby attest that I understand my obligation to report child abuse as describes above and will fulfill this obligation.

Initials: _________

ART HOME HEALTH CARE, INC.

ELDER & DEPENDENT ADULT ABUSE REPORTING RESPONSIBILITY

The California legislature has adopted mandatory reporting requirements for dependent adult and elder abuse. Two aspects of the law are particular concern to the physician:

1. The scope of physician's reporting obligation under the law.
2. The obligation of all physicians and other employees who employ licensed health care practitioners or other mandated reports to provide these employees with a copy of a statement explaining their reporting obligations, and to obtain a signed statement from those employees hired on or after January 1, 1986, acknowledging these responsibilities.

Mandatory Reporting
Reporting is required of physicians, nurses, pharmacies, and all other medical practitioners licensed under Division 2 of the Business & Professional Code. Reporting is also required of certain non-medical practitioners, such as coroners, social workers, psychologists, family counselors, nursing, home ombudsmen, care custodians (certain individuals who work directly with elders or dependent adults as part of their official duties, law officers, and probation and welfare personnel). The obligations does not extend to members of physician's office support staff who are not licenses health care providers. One individual may make the required report for an entire group, and facilities may develop reporting protocols, so long as they are consistent with the statutory requirements. However, if a member of a group learns that the designated individual has failed to make the report, he or she must make the report as soon as practically possible.

Abuse Which Must Be Reported
Those who subject to the reporting obligation must reopen when, within their professional capacity or the scope of their employment, they either:

1. Observe an incident that reasonably appears to be physical abuse.
2. Observe a physical injury where the nature of the injury, its location on the body, or the repetition of the injury clearly indicates that physical abuse has occurred.
3. Are told by an elder or dependent adult that he or she has experiences behavior constituting physical abuse.

"Physical abuse" which must be reported includes, in addition to physical or sexual assault or barrier, the use of physical or chemical restraints or psychotropic medication 1) for punishment, 2) for a period of time significantly longer than that for which the restraint or medication was authorized by the instructions of a physician providing medical care to the elder or dependent adult at the time the instructions were given, or 3) for any purpose non consistent with the authorization of the physician. It is the opinion of CMA legal counsel that the law does not require reporting of cases involving the appropriate withholding or removal of life-sustaining treatment as otherwise authorized by law.

Initials: __________

"Dependent adults" covered by the law include any person residing in California between the ages of 18 and 64 who have physical or mental limitations which restrict their ability to carry out normal activities and protect their rights, and specifically includes all hospital inpatients.
"Elders" covered by the law include all persons residing in California 65 years of age or older.

Discretionary Reporting
Those required to report physical abuse as described above may, but are not required to, report known or reasonably suspected instances of other types of elder or dependent adults abuse, including cases of mental abuse, fiduciary abuse, neglect, abandonment, isolation, or other treatment with resulting physical harm, pain, or mental suffering, or the deprivation by care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

"Isolation" includes:

1. Acts intended to prevent, and that do prevent, an elder or dependent adults from receiving 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 to meet with the visitor, where the statement is false, contrary to the express wishes of the elder or dependent adult from having contact with family, friends, or concerned persons.
3. False imprisonment (as defined in Penal Code 236).
4. Physical restraint of an elder or dependent adult for the purpose of preventing the person from meeting with visitors.

The above acts are subject to a rebuttal presumption that they do not constitute isolation if they are performed pursuant to the instructions of a physician who is caring for the elder or dependent adult and who gives the instructions as part of their person's medical care. Furthermore, the above acts do not constitute isolation if they are performed in response to a reasonably perceived threat of danger to property or physical safety.

Reports

Reports by telephone and in writing must be made to:

1. The long term care ombudsman coordinator or local law enforcement agency (the city police or County sheriff's department, or County probation's department) when the abuse is alleged to have occurred in a long-term care facility, or
2. To the county adult protective services agency (County Welfare Department) or local law enforcement agency when the abuse is alleged to have occurred anywhere else.

Initials: _________

Anti-Retaliation

ART HOME HEALTH CARE, INC. prohibits retaliation made against any employee, volunteer, board member, or patient who reports a good faith complaint of sexual abuse or who participates in any related investigation. Making false accusations of sexual abuse in bad faith can have serious consequences for those who are wrongly accused. The organization prohibits making false and/or malicious sexual abuse allegations, as well as deliberately providing false information during an investigation. Anyone who violates this rule is subject to disciplinary action, up to, and including, termination.

Investigation and Follow Up

ART HOME HEALTH CARE, INC. will take all allegations of sexual abuse seriously and will promptly and thoroughly investigate whether sexual abuse has taken place. The organization will cooperate fully with any investigation conducted by law enforcement or other regulatory agencies. It is the organization's objective to conduct a fair and impartial investigation. The organization provides notice that they have the option of placing the accused on a leave of absence or on a reassignment to non-patient contact.

The organization will make every reasonable effort to keep the matters involved in the allegation as confidential as possible while still allowing for a prompt and thorough investigation.

ACKNOWLEDGEMENT & UNDERSTANDING OF SEXUAL ABUSE POLICY

I acknowledge that I have received and read the sexual abuse policy and/or have had it explained to me. I understand that the organization will not tolerate any employee, volunteer, board member, or third party who commits sexual abuse. Disciplinary actions will be taken against those who are found to have committed sexual abuse.

I understand that it is my responsibility to abide by all rules contained in the policy. I also understand how to report incidents of sexual abuse as set forth in the abuse policy, including retaliation against my employee/ volunteer exercising his/her rights under the policy.

I hereby attest that I understand my obligation to report elder sexual abuse as described above and will fulfill this obligation.

Employee/ Contractor Signature: ______________________________ Date: ______________

YOUR ROLE IN PATIENTS RIGHTS

- Be empathetic to the patient, his/her problems, and situation
- Review the patient rights & responsibilities form with the patient
- Treat all information about the patient as confidential, take measures to safeguard the patient's record
- Inform the patient about how to contact the office during and after office hours and of important reasons to contact the office
- Write down the names of the persons who will be making home visits for the patient
- Inform the patient on how he/she can file a complaint
- When the patient makes a complaint, report back to him/her on how the problem was resolved
- Teach the patient about his/her medical condition and the related care and management
- Coordinate patient care by communicating effectively and frequently with the other members of the team involved in the patient's carc

Employee/ Contractor Signature: ______________________________ Date: ________________

ART HOME HEALTH CARE, INC.

YOUR ROLE IN INFECTION CONTROL

- Practice good hand washing before and after all patient contact
- Use universal precautions for all patients
- Instruct patients and caregivers in the infection control measures that are necessary for each individual case (i.e., immunosuppressed, IV, wound care) and document
- Hand sharps with extreme care. Do not bend, recap, or manipulate in any way
- Double bag, close securely, and dispose in the trash any waste soiled with body fluids
- Place sharps only in a sharps container or a container of impervious plastic which can be closed
- Keep your hands away from your mouth, nose, and eyes as much as possible and especially during patient care
- Be careful to keep your skin, especially the skin on your hands, intact and healthy
- Report any needle stick or mucous membrane exposure to blood or body fluids immediately to your supervisor
- All members of the team (nurses, aides, homemakers) should be alerted to the signs and symptoms of infection and report them to the Case manager or MD as appropriate
- Monitor those patients susceptible to infection (wounds, Foley, IV, immunosuppressed) for signs and symptoms , such as fever, swelling, or drainage
- For the patient or caregiver who has been taught a procedure, periodically re-evaluate their technique to assure it is still adequate
- Use good technique with all sterile procedures
- Be certain patients and caregivers are independent and use good technique before having them do procedures on their own

Employee/ Contractor Signature: ______________________________ Date: ________________

ART HOME HEALTH CARE, INC.

ACKNOWLEDGEMENT & UNDERSTANDING OF POLICIES & ORIENTATION PROCEDURES

1. Acknowledge receipt & understanding of the following:

    - Employee handbook
    - Job description
    - Child abuse & neglect reporting policy & procedure
    - Elder & dependent adult abuse reporting policy & procedure
    - Confidentiality policy & acknowledgement

2. I understand that in accordance with the home health care, standards, State, and Federal regulation, it is my responsibility to provide **ART HOME HEALTH CARE, INC.** with me current license, CPR, Health Certificate, and other job related materials as directed.

3. I will assume responsibility and submit all required documents to **ART HOME HEALTH CARE, INC.** within 10 business days from today's date.

4. I will assume responsibility and provide an update of my health certificate, renewal of my CPR certificates, and current license renewal, if appropriate

I understand that failure to complete all of the above will prevent me from being assigned.

Employee/ Contractor Signature: ______________________________ Title: ________________

Agency Representative Signature: ______________________________ Date: ________________

ART HOME HEALTH CARE, INC.

EMPLOYEE HANDBOOK ACKNOWLEDGEMENT RECEIPT

This is to acknowledge that I have received a copy of **ART HOME HEALTH CARE, INC.**'s Employee Handbook and understand that it sets forth the terms and conditions of my employment as well as the rights, duties, responsibilities, and obligation of employment with the company. I understand and agree that it is my responsibility to read, familiarize myself, and abide with the provisions of this handbook.

I further understand that this is not an employment contract or a legal document.

Employee/ Contractor Name: ______________________________ Title: ______________
Please Print

Employee/ Contractor Signature: ______________________________ Date: ______________

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 2020 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 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)

General Instructions

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;

3. Have self-employment income (see below); or

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

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

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

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

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

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

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

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

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . **1** $ ________

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

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . **2a** $ ________

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . **2b** $ ________

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

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

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

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

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . **1** $ ________

2 Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . **2** $ ________

3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . **3** $ ________

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information **4** $ ________

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . **5** $ ________

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Complete this form so that your employer can withhold the correct California state income tax from your paycheck.

Enter Personal Information	
First, Middle, Last Name	Social Security Number
Address City, State, and ZIP Code	Filing Status ☐ SINGLE or MARRIED (with two or more incomes) ☐ MARRIED (one income) ☐ HEAD OF HOUSEHOLD

1. Total Number of Allowances you're claiming (Use Worksheet A for regular withholding allowances. Use other worksheets on the following pages as applicable, Worksheet A+B). 0
2. Additional amount, if any, you want withheld each pay period (if employer agrees), **(Worksheet B and C)** ____
   OR

Exemption from Withholding

3. I claim exemption from withholding for 2020, and I certify I meet both of the conditions for exemption. ☐ Write "Exempt" here
   OR
4. I certify under penalty of perjury that I am **not subject** to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018. (Check box here) ☐

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Employee's Signature ____________________ Date ________

Employer's Section: Employer's Name and Address	California Employer Payroll Tax Account Number
Art Home Health Care, Inc 16661 Ventura Blvd., #404A Encino, CA 91436	29814092

PURPOSE: This certificate, DE 4, is for **California Personal Income Tax (PIT) withholding** purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

Beginning January 1, 2020, *Employee's Withholding Allowance Certificate* (Form W-4) from the Internal Revenue Service (IRS) will be used for federal income tax withholding **only**. You must file the state form *Employee's Withholding Allowance Certificate* (DE 4) to determine the appropriate California Personal Income Tax (PIT) withholding.

If you do not provide your employer with a withholding certificate, the employer must use Single with Zero withholding allowance.

CHECK YOUR WITHHOLDING: After your DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

EXEMPTION FROM WITHHOLDING: If you wish to claim exempt, complete the federal Form W-4 and the state DE 4. You may claim exempt from withholding California income tax if you meet both of the following conditions for exemption:

1. You did not owe any federal/state income tax last year, and
2. You do not expect to owe any federal/state income tax this year. The exemption is good for one year.

If you continue to qualify for the exempt filing status, a new DE 4 designating EXEMPT must be submitted by February 15 each year to continue your exemption. If you are not having federal/state income tax withheld this year but expect to have a tax liability next year, you are required to give your employer a new DE 4 by December 1.

Member Service Civil Relief Act: Under this act, as provided by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018, you may be exempt from California income tax on your wages if

(i) your spouse is a member of the armed forces present in California in compliance with military orders;

(ii) you are present in California solely to be with your spouse; and

(iii) you maintain your domicile in another state.

If you claim exemption under **this** act, **check the box on Line 4**. You may be required to provide proof of exemption upon request.

The ***California Employer's Guide* (DE 44) (PDF, 2.4 MB)** (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication may be found by visiting **Forms and Publications** (edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm). To assist you in calculating your tax liability, please visit the **Franchise Tax Board (FTB)** (ftb.ca.gov).

If you need information on your last *California Resident Income Tax Return* (FTB Form 540), visit the Franchise Tax Board (FTB) (ftb.ca.gov).

NOTIFICATION: The burden of proof rests with the employee to show the correct California income tax withholding. Pursuant to section 4340-1(e) of **Title 22, California Code of Regulations (CCR)**, the FTB or the EDD may, by special direction in writing, require an employer to submit a Form W-4 or DE 4 when such forms are necessary for the administration of the withholding tax programs.

PENALTY: You may be fined $500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided by section 13101 of the **California Unemployment Insurance Code** and section 19176 of the **Revenue and Taxation Code**.

WORKSHEETS

INSTRUCTIONS — 1 — ALLOWANCES*

When determining your withholding allowances, you must consider your personal situation:

— Do you claim allowances for dependents or blindness?
— Will you itemize your deductions?
— Do you have more than one income coming into the household?

TWO-EARNERS/MULTIPLE INCOMES: When earnings are derived from more than one source, under-withholding may occur. If you have a working spouse or more than one job, it is best to check the box "SINGLE or MARRIED (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with **one** employer.

Do **not** claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 filed for the highest paying job and zero allowances are claimed for the others.

MARRIED BUT NOT LIVING WITH YOUR SPOUSE: You may check the "Head of Household" marital status box if you meet all of the following tests:

(1) Your spouse will not live with you **at any time** during the year;
(2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; **and**
(3) You will file a separate return for the year.

HEAD OF HOUSEHOLD: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the **entire year** for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

WORKSHEET A — **REGULAR WITHHOLDING ALLOWANCES**

(A)	Allowance for yourself — enter 1	(A)	
(B)	Allowance for your spouse (if not separately claimed by your spouse) — enter 1	(B)	
(C)	Allowance for blindness — yourself — enter 1	(C)	
(D)	Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1	(D)	
(E)	Allowance(s) for dependent(s) — do not include yourself or your spouse	(E)	
(F)	Total — add lines (A) through (E) above and enter on line 1 of the DE 4	(F)	0

INSTRUCTIONS — 2 — (OPTIONAL) ADDITIONAL WITHHOLDING ALLOWANCES

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim **one or more additional** withholding allowances. Use last year's FTB Form 540 as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments, or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each $1,000, or fraction of $1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

WORKSHEET B — **ESTIMATED DEDUCTIONS**

Use this worksheet **only** if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1.	Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB Form 540	1.	
2.	Enter $9,074 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $4,537 if single or married filing separately, dual income married, or married with multiple employers	− 2.	
3.	Subtract line 2 from line 1, enter difference	= 3.	0
4.	Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+ 4.	
5.	Add line 4 to line 3, enter sum	= 5.	0
6.	Enter an estimate of your nonwage income (dividends, interest income, alimony receipts)	− 6.	
7.	If line 5 is greater than line 6 (if less, see below [go to line 9]); Subtract line 6 from line 5, enter difference	= 7.	0
8.	Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number. Add this number to Line F of Worksheet A and enter it on line 1 of the DE 4. Complete Worksheet C, if needed, otherwise **stop here.**	8.	0
9.	If line 6 is greater than line 5; Enter amount from line 6 (nonwage income)	9.	
10.	Enter amount from line 5 (deductions)	10.	0
11.	Subtract line 10 from line 9, enter difference **Complete Worksheet C**	11.	0

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California PIT withholding and PIT wages. This law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 1-888-745-3886.

WORKSHEET C **ADDITIONAL TAX WITHHOLDING AND ESTIMATED TAX**

1.	Enter estimate of total wages for tax year 2020.	1.	
2.	Enter estimate of nonwage income (line 6 of Worksheet B).	2.	
3.	Add line 1 and line 2. Enter sum.	3.	0
4.	Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest).	4.	
5.	Enter adjustments to income (line 4 of Worksheet B).	5.	
6.	Add line 4 and line 5. Enter sum.	6.	0
7.	Subtract line 6 from line 3. Enter difference.	7.	0
8.	Figure your tax liability for the amount on line 7 by using the 2020 tax rate schedules below.	8.	
9.	Enter personal exemptions (line F of Worksheet A x $134.20).	9.	0
10.	Subtract line 9 from line 8. Enter difference.	10.	0
11.	Enter any tax credits. (See FTB Form 540).	11.	
12.	Subtract line 11 from line 10. Enter difference. This is your total tax liability.	12.	0
13.	Calculate the tax withheld and estimated to be withheld during 2020. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2020. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2020.	13.	
14.	Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld.	14.	0
15.	Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4.	15.	

NOTE: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the "single" status with "zero" allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

THESE TABLES ARE FOR CALCULATING WORKSHEET C AND FOR 2020 ONLY

SINGLE PERSONS, DUAL INCOME MARRIED WITH MULTIPLE EMPLOYERS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$8,809	1.100%	$0	$0.00
$8,809	$20,883	2.200%	$8,809	$96.90
$20,883	$32,960	4.400%	$20,883	$362.53
$32,960	$45,753	6.600%	$32,960	$893.92
$45,753	$57,824	8.800%	$45,753	$1,738.26
$57,824	$295,373	10.230%	$57,824	$2,800.51
$295,373	$354,445	11.330%	$295,373	$27,101.77
$354,445	$590,742	12.430%	$354,445	$33,794.63
$590,742	$1,000,000	13.530%	$590,742	$63,166.35
$1,000,000	and over	14.630%	$1,000,000	$118,538.96

MARRIED PERSONS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$17,618	1.100%	$0	$0.00
$17,618	$41,766	2.200%	$17,618	$193.80
$41,766	$65,920	4.400%	$41,766	$725.06
$65,920	$91,506	6.600%	$65,920	$1,787.84
$91,506	$115,648	8.800%	$91,506	$3,476.52
$115,648	$590,746	10.230%	$115,648	$5,601.02
$590,746	$708,890	11.330%	$590,746	$54,203.55
$708,890	$1,000,000	12.430%	$708,890	$67,589.27
$1,000,000	$1,181,484	13.530%	$1,000,000	$103,774.24
$1,181,484	and over	14.630%	$1,181,484	$128,329.03

UNMARRIED HEAD OF HOUSEHOLD

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$17,629	1.100%	$0	$0.00
$17,629	$41,768	2.200%	$17,629	$193.92
$41,768	$53,843	4.400%	$41,768	$724.98
$53,843	$66,636	6.600%	$53,843	$1,256.28
$66,636	$78,710	8.800%	$66,636	$2,100.62
$78,710	$401,705	10.230%	$78,710	$3,163.13
$401,705	$482,047	11.330%	$401,705	$36,205.52
$482,047	$803,410	12.430%	$482,047	$45,308.27
$803,410	$1,000,000	13.530%	$803,410	$85,253.69
$1,000,000	and over	14.630%	$1,000,000	$111,852.32

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit **Franchise Tax Board (FTB)** (ftb.ca.gov).

The DE 4 information is collected for purposes of administering the PIT law and under the authority of Title 22, CCR, section 4340-1, and the California Revenue and Taxation Code, including section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California resident income tax return.

Employment Eligibility Verification

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

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

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

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

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

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

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

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

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): ____________
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: ____________
OR
2. Form I-94 Admission Number: ____________
OR
3. Foreign Passport Number: ____________
Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	**List B** Identity	AND	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

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

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A
Documents that Establish Both Identity and Employment Authorization

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:
   a. Foreign passport; and
   b. Form I-94 or Form I-94A that has the following:
      (1) The same name as the passport; and
      (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI

OR

LIST B
Documents that Establish Identity

1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor, or hospital record
12. Day-care or nursery school record

AND

LIST C
Documents that Establish Employment Authorization

1. A Social Security Account Number card, unless the card includes one of the following restrictions:
   (1) NOT VALID FOR EMPLOYMENT
   (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION
   (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Native American tribal document
5. U.S. Citizen ID Card (Form I-197)
6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.

Intuit QuickBooks Payroll

Employee Direct Deposit Authorization

Instructions

Employee: Fill out and return to your employer.

Employer: Save for your files only.

This document must be signed by employees requesting automatic deposit of paychecks and retained on file by the employer. Do **not** send this form to Intuit. Employees must attach a voided check for each of their accounts to help verify their account numbers and bank routing numbers.

Account 1

Account 1 type: ○ Checking ○ Savings

Bank routing number (ABA number): ______________________

Account number: ______________________

Percentage or dollar amount to be deposited to this account: ______________________

Account 2 (remainder to be deposited to this account)

Account 2 type: ○ Checking ○ Savings

Bank routing number (ABA number): ______________________

Account number: ______________________

attach a voided check for each account here

Authorization (enter your company name in the blank space below)

This authorizes ______________________ (the "Company") to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries. I agree that the ACH transactions authorized herein shall comply with all applicable U.S. Law. This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

Authorized signature: ______________________ Employee ID #: ______________________

Print name: ______________________ Date: ______________________