ALAY
HOME CARE

WELCOME LETTER

Dear Applicant,

Welcome and thank you for your interest in working for ALAY Home Care. We are a DDD Provider that dedicate our lives in supporting individuals with Developmental Disabilities.

We need Caregivers like yourself who are dedicated and compassionate in providing the care to our beloved individuals.

Below are the required documents for the position in order to complete the onboarding process.

Please provide the copy of the following Credentials:

- Driver's License
- Social Security Card
- Permanent Resident Card or Workers Permit for non-US Citizen
- Auto Insurance
- Auto Registration
- CPR/First Aid Certification
- Highschool Diploma, Equivalent or higher
- Fingerprint Appointment
- Fingerprint Receipt
- Headshot photo for Company ID

We will also set you up for the following:

- Drug Screen – Pre-employment
- CDS online classes – (You will receive your login once Application Packet is completed)
  https://login.elsevierperformancemanager.com/systemlogin.aspx?virtualname=EMBCenter
  Log in: initial of your first name + last name + last 4 of your social security number
  - Example: jsmith1234
    Password: hello

Tutorial on How to Download, Sign up, and Register for HHAeXchange + Mobile App: https://vimeo.com/1128374933?fl=pl&fe=cm

Alay Home Care Orientation: https://youtu.be/xHsoVNHRSlo

NOTE: We advise ALL our applicants to use paperless version of our Application.
Computer or Laptop – download Adobe Acrobat and start with the Fillable Page (the last page of the application packet) Review each filled document and sign the employee signatures for each document.

Mobile – using your smartphone, download the Adobe Fill and Sign App. Open and complete the application packet.

Send the completed application packet to the recruitment team email.

Welcome and thank you for being part of our team ALAY! #ALAYHOMECARE

Sincerely,

ALAY
HOME CARE

recruitment@alayhc.com
Office: 201-899-4990 Ext. 2

ALAY
HOME CARE

EMPLOYMENT APPLICATION

DATE _____
MM / DD / YYYY

APPLICANT INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL | SSN | DOB

ADDRESS | PHONE | CELL

STATE | ZIP | EMAIL

EMERGENCY CONTACT NAME | RELATIONSHIP | EMERGENCY PHONE

SKILL LEVEL/LICENSE/CERTIFICATION | LICENSE# | EXPIRATION DATE

DO YOU HAVE MALPRACTICE INSURANCE (LPN OR RN)? Y N | IF YES, COMPANY | AMOUNT

Do you have your own car? (if yes check the box, if no leave blank) ☐

EDUCATION

(MM/DD/YYY)

1. SCHOOL/COLLEGE/NURSING SCHOOL | FROM | TO | DIPLOMA/DEGREE

ADDRESS | EMAIL

2. SCHOOL/COLLEGE/NURSING SCHOOL | FROM | TO | DIPLOMA/DEGREE

ADDRESS | EMAIL

WORK EXPERIENCE

(MM/DD/YYY)

1. EMPLOYER | FROM | TO | REASON FOR LEAVING

ADDRESS | POSITION | PHONE

2. EMPLOYER | FROM | TO | REASON FOR LEAVING

ADDRESS | POSITION | PHONE

I authorize Alay Home Care to verify my experience and request information about me from the references identified above.

SIGNATURE | DATE

FOR OFFICE USE ONLY

ALAY SUPERVISOR/TITLE:_____ | INTERVIEW DATE | ORIENTATION DATE

COMPLIANCE: Y OR N | HIRE DATE | START DATE

PLEASE READ THE FOLLOWING AND SIGN:

I hereby authorize each of my former employers and/or agencies given as reference, to respond truthfully to all inquiries made by Alay Home Care and give all other pertinent information that may be sought by Alay Home Care.

In consideration of Alay Home Care placing me, I agree not to directly or indirectly accept or seek employment from any client of Alay Home Care that I have been assigned to, for a period of not less than three (3) months from the last date I was assigned to the client. This restriction shall remain in force up to three (3) months after the last date I was placed by Alay Home Care. If I violate this agreement, I agree to pay upon demand, to Alay Home Care, the sum of $750.00 as liquidated damages.

The following "Employment at Will Statement" ensures that neither the employee nor the agency is bound by the contract for lifetime employment. As an employee you have the right to terminate your employment with Alay Home Care at any time and for any reason. Alay Home Care reserves that same right. The "Employment at Will Statement" is not unique to Alay Home Care, and does not represent a change from past policies and practices.

EMPLOYMENT AT WILL STATEMENT

I understand that my employment may be terminated with or without cause and with or without notice any time at the option of either the agency or myself. I further understand that no management representative has any authority to enter into any agreement of employment for any specific period of time or to make any agreement contrary to the foregoing.

I hereby authorize Alay Home Care to submit a request to the Attorney General of the United States to conduct a search of the records of the Criminal Justice Information Services Division of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints or other identification information submitted by me. I further authorize the exchange of such information between the Attorney General of the United States, the State of New Jersey Department of Human Services and Alay Home Care. This information may be used only by Alay Home Care and only for the purpose of determining my suitability for employment in a position involved in direct patient care.

I hereby release Alay Home Care from any and all claims I may have for its decision not to employ me based upon the Criminal History Record Check results it obtains. I understand that I will not be eligible for unemployment insurance benefits if I am terminated for cause, including termination based upon conviction for a criminal act constituting a felony or any other regulatory disqualifying act.

I swear and affirm to Alay Home Care that I have not, in the State of New Jersey or elsewhere, had a finding rendered against me concerning any patient or resident abuse or been convicted for any crime or violation other than a traffic infraction, except as specifically disclosed below: (List any criminal history here, including dates, locations, (city, county and state), sentence or penalties):

_____

_____

_____

This document shall not be considered a valid application until signed in the presence of an Alay Employee or Representative.

By signing below, I attest that all information provided by me to Alay Home Care and on this Employment Application is true and accurate to the best of my knowledge.

As part of my conditions of employment with Alay Home Care, I authorize Alay Home Care or its agents to conduct the following background checks and or consumer reports: *Criminal Background Screening *Social Security Number Verification *Education Verification *Employment Verification *Professional/Personal Verification *Drug Screening *Driver Abstract/History Record

_____ _____

SIGNATURE DATE

_____ _____

NAME PRINTED SSN

_____

ADDRESS

_____ _____ _____

CITY STATE ZIP

ALAY
HOME CARE

EMPLOYMENT REFERENCE CHECK

I hereby authorize my former employer(s) to release to Alay Home Care any and all information, including, but not limited to, written documentation regarding my employment and termination with the company mentioned below.

Applicant Name: _____ SS#: XXX – XX – _____

Date: Applicant Signature: _____

Company Name: _____ Unit/Area Worked: _____

Company Phone: _____ Company Fax: _____

Reference Name: _____ Title: _____

Time Employed/known: From_____to _____

TO BE COMPLETED BY APPLICANT

Please check box

☐ Personal Reference

☐ Work Reference

Applicant NOT to Write Below this Line

TO BE COMPLETED BY PREVIOUS or CURRENT EMPLOYER

The above named applicant is seeking employment with Alay Home Care and has listed your organization as a former place of employment. In accordance with the Release signed by the applicant, please provide the information requested below. We appreciate your cooperation with providing the information below and answering the following questions. Your responses will be held in the strictest of confidence and will not be released to the applicant. Thank you in advance for your assistance.

Are these dates correct?_____If No: From_____to_____Would you Rehire ☐ Yes ☐ No

Position(s) Held by Applicant: _____

Reason for Separation: ☐ Voluntary Resignation ☐ Termination ☐ Temporary/Seasonal ☐ Other: _____

EMPLOYEE EVALUATION	ABOVE AVERAGE	AVERAGE	ACCEPTABLE	UNSATISFACTORY
Quality of work				
Quantity of Work Performed				
Communication Skills				
Attendance/Punctuality				
Personal Appearance				
Initiative				
Dependability				
Ability to get along with others				

Your Signature:_____ Print Name: _____

Your Title: _____

Company Name/Stamp:_____ Telephone: _____

Verified By:	**Date:**

ALAY
HOME CARE

EMPLOYMENT REFERENCE CHECK

I hereby authorize my former employer(s) to release to Alay Home Care any and all information, including, but not limited to, written documentation regarding my employment and termination with the company mentioned below.

Applicant Name: _____ SS#: XXX – XX – _____

Date: Applicant Signature: _____

Company Name: _____ Unit/Area Worked: _____

Company Phone: _____ Company Fax: _____

Reference Name: _____ Title: _____

Time Employed/known: From_____to _____

TO BE COMPLETED BY APPLICANT

Please check box

☐ Personal Reference

☐ Work Reference

Applicant NOT to Write Below this Line

TO BE COMPLETED BY PREVIOUS or CURRENT EMPLOYER

The above named applicant is seeking employment with Alay Home Care and has listed your organization as a former place of employment. In accordance with the Release signed by the applicant, please provide the information requested below. We appreciate your cooperation with providing the information below and answering the following questions. Your responses will be held in the strictest of confidence and will not be released to the applicant. Thank you in advance for your assistance.

Are these dates correct?_____If No: From_____to_____Would you Rehire ☐ Yes☐ No

Position(s) Held by Applicant: _____

Reason for Separation: ☐ Voluntary Resignation ☐ Termination ☐ Temporary/Seasonal ☐ Other: _____

EMPLOYEE EVALUATION	ABOVE AVERAGE	AVERAGE	ACCEPTABLE	UNSATISFACTORY
Quality of work				
Quantity of Work Performed				
Communication Skills				
Attendance/Punctuality				
Personal Appearance				
Initiative				
Dependability				
Ability to get along with others				

Your Signature:_____ Print Name: _____

Your Title: _____

Company Name/Stamp:_____ Telephone: _____

Verified By: **Date:**

APPENDIX A

COMMUNITY AGENCY HEAD AND EMPLOYEE CERTIFICATION, PERMISSION FOR BACKGROUND CHECK AND RELEASE OF INFORMATION

I hereby authorize the Department of Human Services to conduct a criminal history background check and I agree to be fingerprinted in order to complete the state and federal background check process. I further authorize the release of all information regarding the results of my background check to the Department of Human Services. Check one of the options below.

Option 1_____☐_____I hereby certify under penalties of perjury, that I have not been convicted of any of the offenses listed below and no such record exits in the State Bureau of Identification in the Division of State Police or in the Federal Bureau of Investigation, Identification Division.

Option 2_____☐_____I hereby affirm that I have been convicted of the following offense listed below_____on _____.
(date)

If I have checked Option 2 or the criminal history background check reveals any conviction(s) for the offenses listed below, I understand that I may be subject to termination from employment.

Offenses covered under P.L. 1999, C. 358:

In New Jersey, any crime or disorderly person offense:
-involving danger to the person set forth in N.J.S.A. 2C:11-1 et seq. through 2C:15-1 et seq. including the following:

i. Murder
ii. Manslaughter
iii. Death by auto
iv. Simple assault
v. Aggravated assault
vi. Recklessly endangering another person
vii. Terroristic threats
viii. Kidnapping
ix. Interference with custody of children
x. Sexual Assault
xi. Criminal sexual contact
xii. Lewdness
xiii. Robbery

-against the children or incompetents as set forth in N.J.S.A 2C:24-1 et seq. including the following:

i. Endangering the welfare of a child

ii. Endangering the welfare of an incompetent person

-a crime or offense involving the manufacture, transportation, sale, possession or habitual use of a controlled dangerous substance as defined in N.J.S.A. 2C:24-1 et seq.

-in any other state or jurisdiction, conduct which, if committed in New Jersey, would constitute any of the crimes or disorderly persons offenses described above.

FOR COMMUNITY AGENCY HEAD: I understand the results of this background check will be reported to the President of the Board of my agency. (if applicable)

PLEASE LIST THE NAME AND HOME OR BUSINESS ADDRESS OF THE BOARD PRESIDENT. (if applicable)

_____

_____

_____

_____ _____

Employee Name (please Print) Employee Signature Date

_____ _____

Witnessed by (please print) Witness Signature Date

IdentoGO

Fingerprint Service Code Form

Service Name: ALAY HOME CARE

To Schedule your ten-minute fingerprint appointment, simply visit https://uenroll.identogo.com and enter the following Service Code

2F16S7

When prompted, please enter the following:
Contributor Case Number: PC 3183

Service Code is unique to your hiring/licensing agency. ***Do not use this code for another purpose.***

Please bring one of the identification documents from the list below to your enrollment appointment. Identification must be valid, not expired, and contain a photograph of the applicant.

- Driver's License issued by a State or outlying possession of the U.S.
- Driver's License PERMIT issued by a State or outlying possession of the U.S.
- Driver's License PAPER/TEMPORARY issued by a State or outlying possession of the U.S.
- Enhanced Driver's License (EDL)
- Commercial Driver's License issued by a State or outlying possession of the U.S.
- Commercial Driver's License PERMIT issued by a State or outlying possession of the U.S.
- ID card issued by a federal, state, or local government agency or by a Territory of the United States
- Enhanced Tribal Identification Card (for federally recognized U.S. tribes)
- U.S. Coastguard Merchant Mariner Card
- U.S. Passport
- Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
- Employment Authorization Card/Document (I-766) that contains a photograph
- Canadian Driver's License
- Foreign Driver's License (Mexico and Canada Only)
- U.S. Visa issued by the U.S. Department of Consular Affairs for travel to or within, or residence within, the United States

IMPORTANT! Retain your receipt of fingerprinting and return promptly to your employer.

Fingerprint Appointment Date: _____

Don't have access to the Internet? You can still schedule an appointment by calling **877.503.5981.**

ALAY HOME CARE

DECLARATION FORM

Employee Name: _____ Date: _____

Declaration of Clear Record:

I hereby declare that I was never held civilly liable for abuse or neglect of an individual with developmental disabilities.

Signed: _____

Records Information Permission Form:

I hereby give Alay Home Care permission to contact Boggs Center or College of Direct Support to access any necessary information or documentation such as training documentation that may be need in reference to my employment.

Signed: _____

Picture Release Form:

I give permission for photographs or videos to be taken of me during my employment with Alay Home Care. I understand that these pictures or videos may be used for informational or educational brochures, presentations, or other public presentation purposes.

☐ Agree ☐ Disagree ☐ For Employee ID Purposes only

Signed: _____

Clean Driving Record Statement:

In order to provide transportation to individual I work with, I hereby ascertain that I have a driver's license that is valid in the State of New Jersey, and that I have a clean driving record. I will inform Alay Home Care immediately if my driving record is ever compromised. Staff may not transport individuals if they do not have a clean driving record. In addition, I ascertain that I maintain current insurance coverage on the vehicles I drive at all times. As required by DDD, I hereby give Alay Home Care permission to conduct a driver's records abstract check at any time.

☐ I will be providing transportation ☐ I will not be providing Transportation

Signed: _____

Declaration of Education Requirement:

I understand that the education eligibility for a Community Support Staff Position at Alay Home Care requires that at a minimum the staff member has completed their high school education, or its equivalent. I hereby ascertain that I have completed my high school education requirements or its equivalent (GED).

Signed: _____

For Office Use Only

Provided a copy of Diploma: Y N Date Contacted School for Diploma: _____

Verified By: _____ Date: _____

ALAY HOME CARE

KOMNINO'S LAW ACKNOWLEDGEMENT

Acknowledgement of Receipt of Information Regarding "Komnino's Law"

I have received the following information pertaining to Komnino's Law:

Komnino's Law (P.L. 2017 Chapter 238), provides protections for individuals with developmental disabilities through accountability and transparency.

Protections have been made as follows:

1. **Random and frequent DHS Site visits –** Unannounced visits and evaluations from DHS designated employees will take place multiple times per year. Staff must allow properly identified individuals into the program and provide requested information as needed for the visit/evaluation.

2. **Reporting Injury Timeline –** Every staff member must report to their manager, any injury to service recipients including those as a result of abuse, neglect or exploitation, as soon as it is safe to do so and immediately if the situation allows. Management will relay needed information to DDD, guardians, and HIPAA approved individuals within the 2-hour timeframe for reporting.

3. **Drug Testing -** Any person applying for employment as a direct care staff member at a program, facility, or living arrangement licensed or funded by the department (DHS), shall consent to and undergo drug testing for controlled dangerous substances as a condition of such employment.
    a. Testing positive for unlawful use of any dangerous controlled substance or refusing to submit to drug testing will prevent consideration of employment.
    b. Employees will be selected randomly throughout the year for drug testing. Testing positive for unlawful use of any dangerous controlled substance or refusing to submit to drug testing will result in employment termination.

4. **Meetings with and sharing Contact information -** In order to provide an opportunity for parents and guardians to share experiences about the individuals in accordance with Komnino's Law, the agency will request contact information from each parent or guardian of an individual with a developmental disability. The agency will advise the parent or guardian that, if the parent or guardian agrees, the agency will exchange contact information with other parents and guardians of individuals with developmental disabilities.

I acknowledge that I have received training on Komnino's Law, how it affects my workplace and what my responsibilities are in these situations.

_____
Staff Name Printed

_____ _____
Signature Date

CHRIS CHRISTIE
GOVERNOR

KIM GUADAGNO
LT. GOVERNOR

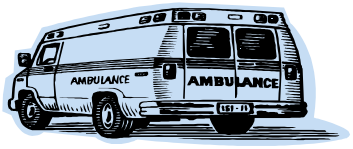
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES
PO BOX 726
TRENTON, NJ 08625-0726

Jennifer Velez
COMMISSIONER

Kenneth W. Ritchey
Assistant Commissioner

TEL. (609) 631-2200

Acknowledgement of Receipt of Information Regarding *"Danielle's Law"*



I have received the following information pertaining to Danielle's Law:

In accordance with Danielle's Law, 911 is to be called in life threatening emergencies. As defined in the law, "Life threatening emergency means a situation in which a prudent person *could* reasonably believe that immediate intervention is necessary to protect the life of a person receiving services, or to protect the lives of other persons at the facility or agency from an immediate threat or actual occurrence of a potentially fatal injury, impairment to bodily functions or dysfunction of a bodily organ or part."

Failure to call 911 in a life threatening emergency includes monetary fines: $5,000 for the first offense, $10,000 for the second offense, and $25,000 for the third and each subsequent offense. Additionally, a health care professional, licensed or alternately authorized to provide services, may be subject to revocation of that professional license or other authorization to practice as a health care professional.

I have received training on Danielle's Law including a Power Point Presentation on Danielle's Law, a copy of Danielle's Biography, a Fact Sheet on Life Threatening Emergencies, and a copy of Chapter 191, the actual Law.

I understand that it is my responsibility to call 911 if a person served by the Division of Developmental Disabilities is experiencing a life threatening emergency, as defined in Danielle's Law." I understand it is the responsibility of the emergency medical professionals to assess the severity of the emergency. My responsibility is to make the call to 911, provide information regarding the condition of the person, and direct emergency workers to the scene of the emergency. It is also my responsibility to provide immediate care until the emergency medical professionals arrive and take over.

_____ _____

Signature **Date**

_____ _____

Print Name **Title**

The Central Registry of Offenders Against Individuals with Developmental Disabilities
Employee/Volunteer Consent for Employers to Check Form
N.J.A.C. 10:44D

Please Complete the Following Information:

Employee/Volunteer Last Name: _____ First Name: _____

Other Last/First Names Used: (please list any/all last names used, including maiden name, nicknames or other)

_____ _____ _____

D.O.B.: _____ Last Four (4) Digits of Social Security Number: _____

Agency/Facility Name: ALAY HOME CARE

In accordance with *N.J.S.A. 30:6D-73 et seq.*, I understand that providing my employer/prospective employer with the above information is for the purpose of my employer/prospective employer conducting a check of my name/identity against the NJ Department of Human Services'(DHS) Central Registry of Offenders Against Individuals with Developmental Disabilities (Central Registry) for the purpose of working/volunteering at an agency/facility/program, licensed, regulated or contracted with the Department of Human Services.

I understand that while I am awaiting the results of the Central Registry check, I may not work unsupervised with individuals with developmental disabilities and that I must be accompanied by a senior staff member or supervisor in any activities involving individuals with developmental disabilities.

By signing this agreement, I attest that the information I have provided above is factual and correct and I can be terminated from employment/volunteering for failure to provide accurate information.

I further attest that I am currently not on the NJ DHS Central Registry of Offenders Against Individuals with Developmental Disabilities. I understand that if my name appears on the Central Registry, I may not be employed/allowed to volunteer in a program licensed, contracted or funded, directly or indirectly by the State of New Jersey to work with individuals with developmental disabilities.

I understand that also under *N.J.S.A. 30:6D-73 et seq.*, in my capacity as an employee, caregiver or volunteer, in a program or facility licensed, regulated or contracted with DHS, or receiving state funding directly or indirectly, I am required to immediately report any/all allegations of abuse, neglect and/or exploitation against an individual with a developmental disability to the NJ Department of Human Services and that failure to do so, while having reasonable cause to believe such an act was committed, constitutes a disorderly persons offense. I understand that when making such a report, in good faith, I am immune from any civil or criminal liability that might otherwise attach from the act of making the report. I understand that in situations of discrimination or discharge from employment as a result of making a report in good faith, I may seek court relief for such actions.

I further understand that I am required to cooperate with investigations conducted by DHS or its designee(s). I have read and understand the above and hereby give my consent for my name to be checked against the Department of Human Services, Central Registry of Offenders Against Individuals with Developmental Disabilities.

_____ _____ _____

Employee/Prospective Employee/Volunteer Name (please print) Signature Date

Provider Agency Use Only
The above named individual has been checked against the Central Registry of Offenders Against Individuals with Developmental Disabilities in accordance with N.J.A.C. 10:44D

*Registry Check Performed By:*_____ *Date:* _____ *Listed on Registry* *Yes*____ *No*____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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

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

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

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

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

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



Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
Vasquez	Katherine	ALAY Home Care

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
31 Newark Bay Ct.	Bayonne	NJ	07002

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2026

Step 1: Enter Personal Information

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

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

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4: Other Adjustments

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

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

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

Exempt from withholding

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

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
ALAY HOME CARE 31 NEWARK BAY CT BAYONNE, NJ 07002		EIN - 83-1431495

General Instructions

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

Future Developments

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

Purpose of Form

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

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

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

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

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

2. Expect to work only part of the year;

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

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

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

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

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

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

Specific Instructions

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

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

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

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



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

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

Step 4.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

- **a** **Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000 . . . . . **1a** $
- **b** **Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation . . . . . **1b** $
- **c** **Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000 **1c** $

2 Add lines 1a, 1b, and 1c. Enter the result here . . . . . **2** $

3 **Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):

- **a** Enter $6,000 if you are age 65 or older before the end of the year . . . . . **3a** $
- **b** Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment . . . . . **3b** $

4 Add lines 3a and 3b. Enter the result here . . . . . **4** $

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information . . . . . **5** $

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

- **a** **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income . **6a** $
- **b** **State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately) . **6b** $
- **c** **Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) . . . . . **6c** $
- **d** **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income . . . . **6d** $
- **e** **Other itemized deductions.** Enter the amount for other itemized deductions . . . . . **6e** $

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here . . . . . **7** $

8 **Limitation on itemized deductions.**

- **a** Enter your total income . . . . . **8a** $
- **b** Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** $

9 Enter:
- $768,700 if you're married filing jointly or a qualifying surviving spouse
- $640,600 if you're single or head of household
- $384,350 if you're married filing separately

. . . . . **9** $

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here . . . . . **10** $

11 **Standard deduction.**

Enter:
- $32,200 if you're married filing jointly or a qualifying surviving spouse
- $24,150 if you're head of household
- $16,100 if you're single or married filing separately

. . . . . **11** $

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly) . . . . . **12** $

13 Add lines 11 and 12. Enter the result here . . . . . **13** $

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 . . . . . **14** $

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 . . . . . **15** $

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

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

Single or Married Filing Separately

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

Head of Household

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

ANNUAL PLEDGE OF CONFIDENTIALITY

I,_____, _____

(PRINT NAME AND TITLE)

Fully understand that all patient information, clinical and administrative records are confidential material to be treated as confidential to respect and protect the rights of patients, adhere, to Federal Law (HIPAA) regarding the protection of patient health information and maintain the credibility of the Company.

I have also been oriented to the Company's policy on confidentially HIV Related Information.

I am aware that:

Only those personnel who need information to provide health care to a patient have the right to read records, in so far as his/her job requires it. This information must be kept confidential and discussed in a private setting only by those involved in his/her care.

No person to whom confidential HIV Related Information has been disclose shall disclose the information to another person except as authorized by law.

During my initial orientation, I was given and hold a copy of the Orientation Manuel/Employee Handbook, which contains information on confidentiality, HIV confidentiality and includes the agency's Ethics Statement.

It is my responsibility to protect the right of confidentiality of all patients.

As an employee of Alay Home Care, I have read the entire agency's policies and procedures as they relate to confidentiality.

I understand any violation of this policy can result in termination.

_____	_____	_____
(Signature)	(Title)	(Date)

ALAY
HOME CARE

ORIENTATION ACKNOWLEDGEMENT FORM

VERIFICATION OF:

1. Orientation to Agency Policy and Procedure Manual (Mission, Philosophy, Goals,Services and Practices)
2. HHAeXchange Mobile App Training
3. Receipt of Job Description
4. Receipt of Employee Handbook
5. Receipt of Health Insurance Enrollment/Waiver Form
6. Receipt of Photo I.D.

IMPORTANT NOTICE

I hereby authorize each of my former employers and/or agencies given as reference, to respond truthfully to all inquiries made by Alay Home Care and give all other pertinent information that may be sought by Alay Home Care.

In consideration of Alay Home Care placing me, I agree not to directly or indirectly accept or seek employment from any client of Alay Home Care that I have been assigned to, for a period of not less than three (3) months from the last date I was assigned to the client. This restriction shall remain in force up to three (3) months after the last date I was placed by Alay Home Care. If I violate this agreement, I agree to pay upon demand, to Alay Home Care, the sum of $750.00 as liquidated damages.

The following "Employment at Will Statement"ensures that neither the employee nor the agency is bound by the contract for lifetime employment. As an employee you have the right to terminate your employment with Alay Home Care at any time and for any reason. Alay Home Care reserves that same right. The "Employment at Will Statement"is not unique to Alay Home Care, and does not represent a change from past policies and practices.

EMPLOYMENT AT WILL STATEMENT

I understand that my employment may be terminated with or without cause and with or without notice any time at the option of either the agency or myself. I further understand that no management representative has any authority to enter into any agreement of employment for any specific period of time or to make any agreement contrary to the foregoing.

I hereby authorize Alay Home Care to submit a request to the Attorney General of the United States to conduct a search of the records of the Criminal Justice Information Services Division of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints or other identification information submitted by me. I further authorize the exchange of such information between the Attorney General of the United States, the State of New Jersey Department of Human Services and Alay Home Care. This information may be used only by Alay Home Care and only for the purpose of determining my suitability for employment in a position involved in direct patient care.

I hereby release Alay Home Care from any and all claims I may have for its decision not to employ me based upon the Criminal History Record Check results it obtains. I understand that I will not be eligible for unemployment insurance benefits if I am terminated for cause, including termination based upon conviction for a criminal act constituting a felony or any other regulatory disqualifying act.

I affirm and acknowledge that I was provided with an employee orientation.

_____

Employee Name (Print)

_____

Employee Signature

_____

Date

HIPAA EMPLOYEE TRAINING ACKNOWLEDGEMENT FORM

STATEMENT

I acknowledge that I have received and thoroughly reviewed Alay Home Care's HIPAA Education Handouts and attended the HIPAA Training session on the date signed below. This session included training on the federal and state laws and regulations regarding the HIPAA privacy and security rules requiring the use of confidentiality as well as integrity accessibility safeguards for patient protected health information (PHI).

I agree to comply strictly with the principles set forth in the Alay Home Care's training on HIPAA and the Organization's Privacy & Security Policies and Procedures, which include but are not limited to:

- Minimum necessary;
- Maintaining confidentiality of PHI;
- Patient privacy rights under HIPAA;
- Password management;
- Log-in procedures and requirements; and
- Identifying and reporting security incidents.

I received training on and understand the policies and procedures specific to my job functions.

I agree to follow the policies and procedures and otherwise maintain the confidentiality and integrity of PHI.

I understand that I will be subject to disciplinary action up to and including termination if I violate the principles set forth in the HIPAA training session.

I further understand that the HIPAA Privacy & Security Policies and Procedures are not a contract of employment.

_____	_____	_____
(Signature)	(Title)	(Date)

ALAY HOME CARE

JOB DESCRIPTION

SUBJECT: **DIRECT SUPPORT PROFESSIONAL JOB DESCRIPTION**

POLICY: The Direct Support Staff is a worker qualified to provide companionship, mentorship, community support, carry out health care tasks, assist with personal hygiene, minor housekeeping (not to exceed 20% of the assignment hours) and other related supportive tasks to the individuals with developmental disabilities within the home and/or the community, under the DDD guidelines.

QUALIFICATIONS:

1. Completion and proficiency with mandatory DDD Trainings
2. Driver's License valid in the state of NJ with a good driver's history
3. A reliable vehicle for community transport with Auto Insurance Policy
3. Must pass the Criminal Background Check
4. Must pass the pre-employment Drug Screen
5. Direct Support Staff will not be listed on the Central Registry
6. Successfully complete the DDD examination with a passing grade of 70%.
7. Able to adequately demonstrate skill review
8. One-year experience working with Developmental Disabilities preferred
9. Able to meet the physical requirement of the position.

TRAINING: Must complete and show proficiency with mandatory DDD Trainings within the appropriate timeframe, including:

1. Overview of Developmental Disabilities
2. Abuse, Neglect and Exploitation
3. Medication Administration
4. Danielle's Law
5. Komnino's Law
6. CPR and First Aid
7. All other additional trainings as necessary

REPORTING RELATIONSHIP: The Direct Support Staff reports to the ALAY Home Care Case Manager. Indirect reporting relationship to the Customer Relationship Manager.

ALAY
HOME CARE

JOB DESCRIPTION

RESPONSIBILITIES:

1. Develops and maintains an interactive relationship with individuals and family members.
2. Exhibits proficiency and implements all tasks needed to service the individuals appropriately including IHP goals, upkeep of the home, and other tasks as needed. Must complete all appropriate documentation properly.
3. Implements recreational activity plans for the individuals in the home with input from the individuals.
4. Develops and implements house menus with input from the individuals.
5. Identifies and implements strategies for maximizing the inclusion of residents in the life of the community.
6. Administers medication and documents such in compliance with ALAY Home Care policies and procedures which conform to DDD guidelines.
7. Schedules and accompanies individual to medical appointments.
8. Completes all DDD required trainings and continues to improve skills through trainings required by ALAY Home Care.
9. Transports individuals to community destinations as necessary.
10. Must cooperate with ALAY Home Care and Department of Human Services staff in any inspection or investigation.
11. Follows through with additional responsibilities and tasks related to care and compliance as assigned by management or administration.
12. Report all incidents both in the community and the residence in a timely manner in accord with ALAY Home Care and DDD guidelines.
13. Report all incidents both in the community and the residence in a timely manner in accord with ALAY Home Care and DDD guidelines.
14. Requires the completion of the Daily Logs in accordance with DDD requirements. Failure to submit them promptly may result in pay being delayed.

Employee Name: _____

Employee Signature:_____**Date:** _____

ALAY HOME CARE

Employee Acknowledgement Form

All employees are aware of the following:

1. Regardless if you are a family member, relative or friend who assists a consumer, you are considered an Employee of Alay Home Care during working hours. You are subject to documentation standards as per DDD.
   a. Daily logs need to be completed at the end of each shift or by Monday at the latest if there are extenuating circumstances
2. Regardless if you are a family member, relative or friend who assists a consumer, you are considered an Employee of Alay Home Care during working hours. You are subject to initial & ongoing staff training as per DDD.
   a. 58 DDD required CDS Modules:
      1 DDD Required (Prior) – Stephen Komninos' Law
      1 DDD Required (Prior) – Life Threatening Emergencies [Danielle's Law]
      1 DDD Required (Prior) – Incident Reporting
      6 DDD Required (Prior to Med Admin) – Intro to Administering Medications
      5 DDD Required (60) – Prevention of Abuse, Neglect, and Exploitation
      9 DDD Required (60) – Understanding and Preventing Life Threatening Health Conditions
      2 DDD Required (60) - Documentation
      3 DDD Required (90) - Universal Precautions
      2 DDD Required (90) - DSP Professionalism
      2 DDD Required (90) - Intro to Developmental Disabilities
      2 DDD Required (90) – Person-Centered Planning
      3 DDD Required (90)- HIPAA
      3 DDD Required (90) - Working With Families
      3 DDD Required (90) – Individual Rights and Choice
      1 DDD Required (90) – Overview of the HCBS Settings Final Rule
      5 DDD Required (120) – Supporting Health & Wellness
      1 DDD Required (120) - Cultural Competence
      1 DDD Required (120) - Understanding Behavior and Effective Supports
      1 DDD Required (120) - Overview of Dual Diagnosis
      1 DDD Required (180) – Intro to Trauma Informed Supports
      5 DDD Required (180) - Everyone Can Communicate
   b. Positive Behavior Supports (PBS) (if applicable)
      i. 7 Positive Behavior Supports CDS
      ii. PBS Boggs Training
      iii. Crisis Prevention & Intervention Training
   c. Pre- Employment Drug Testing
   d. Random Drug Testing
   e. Fingerprinting (Background check)
   f. Child Abuse Registry Information (CARI) submission
   g. Central Registry Check
   h. Driver's Abstract (if applicable)
   i. CPR / First Aid Certification
   j. RN Training (if applicable)
   k. Medication Training (if applicable)
      i. Medication Practicum
   l. Orientation - It covers the content of the employee handbook. summarizing the procedures, policies and practices of the company. For more detailed information, you need to speak with your immediate supervisor
      Annual Professional Development (Mandated Trainings, 12 hours Credits, Orientation, Competencies, Specialized Staff Training, Seminars, Webinars, In-service)
3. DDD hours through the Supports Program (SP) or the Community Care Program (CCP) should NOT overlap with any other government programs, including but not limited to:
   a. Personal Preference Program (PPP)
   b. Personal Care Assistance (PCA)
   c. Day Programs
   d. Medicare
4. Two to one services (2:1) - Any shifts that require 2 caregivers per 1 consumer must be approved through DDD and documented in the ISP.
5. If a consumer is admitted into the hospital, the consumer would be considered under the care and supervision of the hospital. Your Case Manager should be notified so we can submit a Unusual Incident Report (UIR) to DDD. If admitted during working hours, the caregiver should immediately clock out. Services can NOT resume until the consumer has been discharged from the hospital.
   a. If in the ER, you can still provide care
   b. Hospitals are required to let you know what the status is
      i. "Admitted" means the patient is in the hospital under the care of a doctor.
      ii. "Under observation" means the patient is staying in the hospital but as an outpatient.
6. Each caregiver is required to complete 12 hours of DDD approved training credits annually.

Print Name : _____ Date_____

Title : _____ Signature _____

Form **8850**
(Rev. March 2016)
Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

▸ **Information about Form 8850 and its separate instructions is at *www.irs.gov/form8850.***

OMB No. 1545-1500

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name _____ Social security number ▸ _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

If you are under age 40, enter your date of birth (month, day, year) _____

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if **any** of the following statements apply to you.

- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  a. Received SNAP benefits (food stamps) for the past 6 months; **or**
  b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:

- Received TANF payments for at least the past 18 months; **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▸ **Date**

Please fill in these forms slowly and legibly.
Form Updated 01/01/2020

Company Name: Alay Home Care
Company EIN Number: EIN - 83-1431495

Have you ever **worked for *this* Employer before? Are you a Re-hire?**	**Yes** ☐ **No** ☐
Are you under age 40?	**Yes** ☐ **No** ☐
Have you been **unemployed for at least 27 weeks,** and collected Unemployment Insurance?	**Yes** ☐ **No** ☐
Are you a Veteran of the US Armed Forces?	**Yes** ☐ **No** ☐
If *yes*:	
Are you a member of a family that received SNAP (Food Stamps Benefits)?	Yes ☐ No ☐
Are you entitled to compensation for a service-connected disability?	Yes ☐ No ☐
Were you discharged from active duty within the last year?	Yes ☐ No ☐
Were you unemployed for a combined total of 6 months before you were hired?	Yes ☐ No ☐
Have you, or your family, received **SNAP benefits (Food Stamps)** in the **6 months** before you were hired?	**Yes** ☐ **No** ☐
Or received **SNAP Benefits** for at least a **3-month period**, but you are no longer receiving it?	**Yes** ☐ **No** ☐
If yes to either question, enter Name of Primary Recipient: _____	
And City, State where benefits were received_____	
Are you a member of a family that received **TANF** assistance for at least 18 months before you were hired?	**Yes** ☐ **No** ☐
Or, did your family stop being eligible for **TANF** assistance within 2 years before being hired, because you reached the maximum time those benefits can be received?	**Yes** ☐ **No** ☐
If yes to either question, enter Name of Primary Recipient: _____	
And City, State where benefits were received_____.	
Did you receive Supplemental Security Income **(SSI Benefits)** for any month, ending within the 60 days, before you were hired?	**Yes** ☐ **No** ☐
Were you convicted of a **Felony** during the year before you were hired?	**Yes** ☐ **No** ☐
Were you referred to an employer by	
• A Vocational Rehab Agency approved by the state?	**Yes** ☐ **No** ☐
• An Employment Network under the Ticket to Work Program?	**Yes** ☐ **No** ☐
• The Dept. of Veteran Affairs?	**Yes** ☐ **No** ☐

Print Name:	Social Security #:	Date of Birth:
_____	_____ - _____ - _____	_____

By signing this form, I hereby authorize any agency, organization, Social Security Administration, Department of Veterans Affairs, or individuals, to supply verification of information as may be needed to determine tax credit eligibility to my employer, employer representative (TC Services USA, Inc. dba WOTC.com), or the Department of Labor. I also understand that my responses are used, in part or in full, to complete the IRS Form 8850 and any other documents pertaining to the WOTC Program, and that modifications can be made by my employer, or employer representative, in order to enable the verification screening process as required by some states. This information will not in any way affect my employment.

Employment Start Date_____**Starting Wage**_____**Position**_____

Signature_____**Today's Date**_____

WOTC.com
Work Opportunity Tax Credit

FORM 9600 - To Be Completed By All New Hires Revised 05/24/2016

You just completed a Work Opportunity Pre-Screening Notice. We request that you answer the following questions in order to supply supplemental information to determine if the Company is eligible for certain tax credits. This form will be used solely to determine whether the Company qualifies for certain tax credits. The information you provide below will not affect your personal taxes and will not be used in making any decisions about your employment. All information will be kept STRICTLY CONFIDENTIAL.

Your Name _____ Social Security No. _____ - _____ - _____ Date of Birth ____ _____ _____

Have you ever worked for this company before? ☐ yes ☐ no (Do not include time working for a temporary agency for the company)

To be completed by your employer

Starting Wage _____ Job Title _____ Date Started _____

Please check yes or no to ALL questions. It is very important that you answer honestly.

☐ Y ☐ N Are you a member of a **family that has received Public Assistance** (from any government agency) for **any nine months during the 18 months prior to hire?**
If Yes, which program_____ **In which US State did you receive the assistance?** _____

☐ Y ☐ N Are you a member of a family that **received public assistance for at least 18 months**, or **received public assistance benefits for any 18 months beginning after August 5, 1997**, or **stopped being eligible for public assistance after August 5, 1997 because Federal or State Law limited the maximum time those payments could be made?**
If Yes, In which US State did you receive the assistance? _____

☐ Y ☐ N Are you are a Veteran? (Thank you for your service!), please provide your: **branch of service**_____
and **years that you served on active duty:** _____ to _____ and **answer the following questions:**

Are you a **Veteran who was unemployed for more than 4 weeks in the year before working here?**
If yes, have you been unemployed (check one):
☐ less than 4 weeks ☐ 4 weeks to 6 months ☐ more than 6 months

Are you a Veteran and a member of a family who has received food stamps for at least 3 months out of the last 15 months preceding your hire date? ☐ Y ☐ N

Are you a Veteran with a Service Connected Disability with at least a 10% rating? ☐ Y ☐ N

☐ Y ☐ N **Were you unemployed** prior to being hired at this employer? **If yes**, for how many weeks? _____
If yes, Did you receive **unemployment benefits during that time?** ☐ Y ☐ N
In which US State did you receive the benefits? _____

☐ Y ☐ N Have you **been released from Federal or State prison within the last year?** Or, have you **participated in a Work Release program?**
If yes, please provide your **Conviction Date**_____ **Release Date**_____
Which State (or Federal)?_____ **Parole Officer (if any)**_____

☐ Y ☐ N Are you receiving any **Social Security Administration Disability Benefits (SSDI or SSI)** for yourself (not for your children)? **If yes**, please provide your employer with a copy of your **Benefit Verification Letter.**

☐ Y ☐ N Are you a member of a family that has **received food stamps for 6 months before your hire date OR** an able bodied adult without dependents that has received food stamps **for at least 3 of the 5 months** before your hire date **AND** is no longer receiving food stamps? **If yes, In which US State did you receive the assistance?** _____

☐ Y ☐ N Were you referred to your employer by a **Vocational Rehabilitation Agency** approved by the state? **OR**, by an Employment Network under the **Ticket to Work Program?** OR by the **Department of Veterans Affairs?**
If yes, please provide your employer with a copy of your referral.

Participant's Authorization for disclosure of information and declaration: Under penalty of perjury, I declare that the above information is true and correct to the best of my knowledge. I also hereby authorize CFO Resources, Inc., my employer, employer representative, or the State Department of Labor to obtain information from my records to determine eligibility for the Work Opportunity Program.. I also authorize the Department of Social Services, Bureau of Rehabilitation Services, Board of Education and Services for the Blind, Department of Veteran's Affairs, Department of Corrections, and Social Security Administration to release the requested information from my records to CFO Resources, Inc., my employer, employer representative or the Department of Labor for that purpose.

Employee Signature_____ **Date**_____

***If under 18 years of age, requires witness (parent or guardian) signature:

Print Name_____ **Signature**_____ **Relationship**_____

DIRECT DEPOSIT

Authorization Agreement for Direct Deposit

I hereby authorize Alay Home Care to deposit any amounts owed me, as instructed by my employer, by initiating credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Alay Home Care to my account. In the even that Alay Home Care deposits funds erroneously into my account, I authorize Alay Home Care to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until Alay Home Care and Bank have received written notice from me of its termination in such time and in such manner as to afford Alay Home Care and Bank reasonable opportunity to act on it.

Employee Name:_____Social Security #: _____

Employee Signature:_____Date: _____

Account Information:

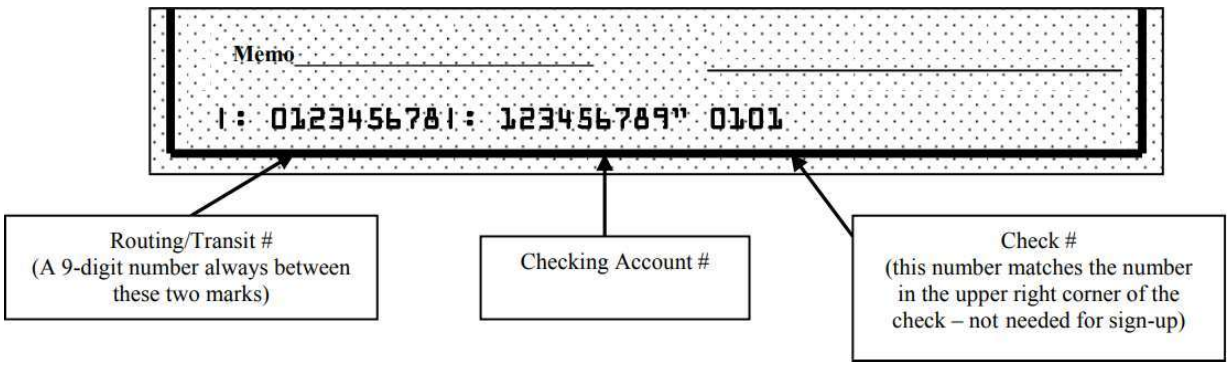
The last item must be for the remaining amount owed to you. To distribute to more accounts, please complete another form.

Make sure to indicate what kind of account, along with amount to be deposited, if less than your total net paycheck.

1. Bank Name/City/State: _____
   Routing Transit #_____Account Number: _____
   ☐ Checking ☐ Savings
   Deposit Request:
   ☐ Specific Dollar Amount $_____.____
   ☐ _____% of Net
   ☐ Entire Net Amount

2. Bank Name/City/State: _____
   Routing Transit #_____Account Number: _____
   ☐ Checking ☐ Savings
   Deposit Request:
   ☐ Specific Dollar Amount $_____.____
   ☐ _____% of Net
   ☐ Entire Net Amount

Below is a sample check MICR line, detailing where the information necessary to complete this form can be found.



SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No.: _____

Policyholder Name: ALAY HOME CARE

Employee Name: _____
Last First MI

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Employment: _____ Date of Birth: _____

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Horizon Blue Cross Blue Shield of New Jersey. I *refuse* the following:

☐ Employee, Spouse and Child(ren) coverage

☐ Spouse coverage

☐ Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

☐ other fully-insured Group Health Plan sponsored by this employer

☐ other Group Health Plan sponsored by my spouse's employer

☐ other group coverage sponsored by another organization

☐ covered under Medicare

☐ other reasons (please explain) _____

Please identify Group Health Plan(s) and provide names(s) of policyholder(s), carrier(s) and policy number(s).

Policyholder/Name: _____ _____ _____
Last First MI

Carrier: _____ Policy Number: _____

Policyholder/Name: _____ _____ _____
Last First MI

Carrier: _____ Policy Number: _____

Policyholder/Name: _____ _____ _____
Last First MI

Carrier: _____ Policy Number: _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 90 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after marriage, birth, adoption or placement for adoption.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form.

_____ Date:
Signature of Employee

_____ Date: _____ / _____ / _____
Signature of Witness MM DD YYYY

An Independent Licensee of the Blue Cross and Blue Shield Association

ALAY HOME CARE

FILLABLE PAGE

Start with this page if you are using your computer to auto fill all the pages prior	
Applicant Information	MM/DD/YYYY
First Name	Application Date
First Letter of Middle Name(ex. A.)	Last Name
Social Security Number	Last 4 of Social (ex:1234)
Date Of Birth (ex. 01/02/2022)	Cellphone Number(ex. (123) 456-7890
Street Address	Phone Number
City/State	Zip Code
Email Address	Emergency Contact Name
Relationship with Emergency Contact	Emergency Contact Number
License/Certification	License/Certification Number
License/Certification Expiration Date	Position/Title (DSP or Other)

Marital Status – W4 (☐ Single/ ☐ Married Filing Jointly/ ☐ Head of Household)	Do you have a CAR for Community Transport (If yes check the box) ☐ Yes ☐ Public Transportation
Education	
School/College/Nursing School (1)	Diploma/Degree
From	To
Address	Email
School/College/Nursing School (2)	Diploma/Degree
From	To
Address	Email
Work Experience and References	
Employer (Work Reference)	Reason for leaving
From	To
Address	Position
Reference Name/Job Position /	Contact Number
Employer	Reason for leaving
From	To
Address	Position
Reference Name/Job Position /	Contact Number

Other Fields	
Have you been convicted ☐ Yes ☐ No	Are you a citizen of United States? Yes ☐ oncitizen ☐ Lawful Resident ☐ Authorized Alien ☐
Bank Name/City/State	Bank Account Number
Bank Routing Number	Checking ☐ Savings ☐ / Entire Net Amount ☐ Specific $ amount
Pre-Employment	
Fingerprint Appointment Date	See Page 8 – IdentoGO form for Fingerprint instructions
	See Page 1 – Welcome Letter for EVV (HHA Exchange App) instructions