BIG HEART HOME CARE
EMPLOYMENT APPLICATION

Name: _____ Date: _____

Address: _____ City:_____

State:_____ Zip Code:_____ Sex:____ SS#:_____ Language:_____

Phone Number: Home_____ Mobile_____ Position:_____

Are you a citizen of US? ( ) Yes ( ) No If no are you authorized to work in US ( ) Yes ( ) No
Have you ever worked for this company ( ) Yes ( ) No If Yes, when? _____
Have you ever been convicted of a felony ( ) Yes ( ) No Explain _____

Education
High School_____ College_____

Serificates/Diploma_____

Special Skills_____

Emergency Contact Information
Name _____ Relationship _____

Address: _____ City: _____

State:_____ Zip:_____ Phone _____ Alt Phone_____

Previous Employer
Company: _____ Phone: _____ Supervisor: _____

Address: _____ Job Title: _____ Salary: _____

From: _____ To: _____ Reason for Leaving: _____

Qualifications
( ) HHA Training School: _____ Certification Date: _____

( ) PCA Training School: _____ Certification Date: _____

Have you ever been sanctioned by Medicaid/Medicare? ( ) Yes ( ) No
Have you ever been bonded? ( ) Yes ( ) No
Have you ever been convicted in crime? ( ) Yes ( ) No

I certify that my answers are true and complete to the best of my knowledge. If this application leads to employment, I understand that false or misleading in my application or interview may result in my release

Signature: _____ Date: _____

For Employer Use Only
Position applied for is ( ) Available ( ) Not Available Approved: ( ) Yes ( ) No Date Hired:_____

Authorized Signature: _____ Date: _____

BIG HEART HOME CARE

1302 KINGS HWY, BROOKLYN, NY 11229

CRIMINAL BACKGROUND CHECK

Where you fingerprinted in the past through other LHCSA?
( ) Yes ( ) No ( ) Don't know

First Name: _____

Last Name: _____ Middle Initial: _____

DOB: _____ Last 4 digit of SSN: _____

Maiden Name: _____ Alias: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Birst Country: _____

Gender ( ) Male ( ) Female

Race ( ) Asian ( ) African American ( ) Native American

( ) White or Hispanic ( ) Unknown

Height: Feet _____ Inch _____ Weight: Pounds _____

Eyes: ( ) Black ( ) Blue ( ) Brown ( ) Gray

( ) Green ( ) Hazel ( ) Other _____

Hair: ( ) Bald ( ) Black ( ) Blonde ( ) Brown

( ) Red ( ) White ( ) Other _____

JOB DESCRIPTION

Position: Home Health Aide / Personal Care Aide
Report to: Director of Patient Services / Nurse
Position Summary: A Home Health Aide/Personal Care Aide is an individual who provides personal care, home management and other related home health supportive services in order to assist the individual to continue living in their home environment when there are disruptions due to illness, disability, social disadvantage or other problems in their home. They are under the direct supervision of the licensed nurse. The HHA/PCA provide care in accordance with the DOH Matrix: Permissible and Non-Permissible Activities: HHA Services.

QUALIFICATIONS

Successful completion of a New York State Department of Health approved Home Health Aide/Personal Care Aide training programs as demonstrated by a valid Home Health Aide/Personal Care Aide Certificate.
*Ability to communicate sufficiently to understand and interpret the Caregiver Plan of Care, document care provided in the HHA/PCA Time and Activity report and able to call agency to report change and/or issues related to the patient and/or 911 in case of an emergency.
*Holds a valid Home Health Aide/Personal Care Aide Certificate.
*Ability to apply common sense understanding to carry out simple one or two step instructions. Ability to deal with standardized situations with only occasional or no variables.

CONTACT:

Patients/Patients families	Provide core and service
Agency staff (coordinator, nurse)	Receive supervision, Development of POC

EQUIPMENT OPERATION:

Walker, Care, Crutches, Wheelchair, Commode, Hospital Bed, Hoyer Lift, Household Appliances (i.e. vacuum, refrigerator, stove, blender, toaster, etc.)

DISCIPLINARY POLICIES AND ACTION FOR FIELD EMPLOYEE:

Big Heart Home Care is an equal opportunity employer and welcome qualified candidates regardless of age, race, creed, color, sexual orientation, disability, citizenship status, national origin, marital status, veteran status or the presence of non-job related medical condition or handicap or any other legally protected status.

1. After 3 times of no show/no calls will be followed by immediate termination from the agency.
2. Abandonment of patients without notifying agency representative/s will also be followed by immediate termination from the agency.

All other violations of Big Heart Home Care Policy will follow these guidelines listed below:

1. Document/verbal warning for 1st violation
2. Written warning with counseling for a 2nd violation
3. A 30/60 days probation for the 3rd violation
4. To be followed by immediate termination of employment after 4th violation.

COMPANY RULES AND POLICY FOR HHA'S AND PCA'S

*Report to your case ON TIME
*If you are going to be late to your assigned case, you must inform the agency at (347) 542-4150 or your coordinator's cell phone immediately.
*If a patient does not open the door, you must call the patient and /or patient's family member and you must also inform your coordinator. DO NOT LEAVE OR GO HOME. You are still on assignment and responsible for your patient and shift.
*Wear our uniform and I.D. AT ALL TIMES while you are on duty.
*If the plan of care is not in the home, call the agency to report it IMMEDIATELY. Let the nurse know as well when he/she visits.
*If your patient is admitted to the Hospital you MIUST call the agency right away with the name of Hospital and time admitted.

*If the patient becomes ill, call 911 before you call the agency or family member(s).
*Any changes in the patient conditions must be reported to the agency immediately example: Eating Patterns, Breathing, Dizziness, Environment, Home Area etc.
*You are required to inform the agency or the on call coordinator if there is no relief at the end of the shift.
*You must stay with your patient during an emergency or disaster until alternative care is in place.
*DO NOT use the patient's phone for any personal reason.
*DO NOT give your personal phone numbers, address, or discuss your personal problems with patient(s) or any of their family members.
*DO NOT use your cell phone while on duty or in the patient's home unless it's an emergency. Leave the phone on vibrate or silent.
*DO NOT read magazines, newspaper, fall asleep or take naps in the patient's home.

*DO NOT make arrangements with the patient to change your schedule. If you or the patients need a change in the time or hours the patient must notify the coordinators and respective health plans immediately.
Report all extra hours worked immediately, if refused by the patient.
*Absolutely no smoking in the patient's home.
*Time Sheets MUST be complete and accurate, no white out, red ink, make sure they are neat, legible and presentable. The agency must have time sheets no later than Tuesday, 12pm of every week in order to get paid on time.

TELEPHONE EMERGENCY POLICYAND PROCEDURES

If the telephone in the office is out of service, the office staff will go to the nearest telephone and inform the telephone company. In addition, we will call each client and inform each client were we can be reached until the telephone is restored. Should there be a disruption in the telephone services for the entire area, office staff will proceed to their homes and begin calling clients to ensure their safety and well-being. Again, staff and clients will be given a number to call should they require assistance or direction. Record keeping - the agency shall maintain a roster of person including their current telephone numbers. A similar roster or list of patients and their telephone number shall be maintained. Any person identified as the highest priority in the disaster shall be noted as such on the roster. Staff shall be advised to routinely and continually notify the coordinator of such patients. To the extent possible record keeping during a disaster shall be through and complete. Attempts to notify staff and patients and the outcome, including alternate plans will be documented. Termination — the director of the agency shall declare when the emergency/ disaster is discontinued. The director shall periodically review the plan.

POLICY AND PROCEDURES MAINTAINING CONFIDENTIALITY OH HIV INFORMATION

1. Field staff supervisors who received HIV related referral information on the phone must maintain confidentiality of such information and may only disclose this information to employees when this knowledge is necessary to provide appropriate care of treatment to the protected person.
2. The caregiver will be oriented to the care and given the diagnosis and plan of care, the diagnosis will not be listed on the plan of care in the home in order to maintain confidentiality.
3. The medical records or client folder will be marked confidential and will remain locked in the medical records cabinet.
4. If formation is required for billing and reimbursement purpose, the records will be treated as confidential when removed from medical records until its return.
5. A method of signing for removal and return of the records will be instituted.
6. Annual in -service education to apprise all field employees of the new state directive regarding confidentiality of HIV related information will be held.
7. When established the office will follow guidelines as per state regulations.
8. Universal precautions will be utilized.
9. All caregiver will be apprised of confidentiality procedures.
10. Confidential HIV related information shall not be disclosed to a health care provider or health care facility for the sole purpose of implementing infection control precautions when such facilities are required under public health law to implement universal precautions with all individuals.

EMERGENCY/DISASTER PLAN

Emergency/disaster plan provides an orderly procedure to be implemented in an emergency to assure that the health care need of patients continue to be met. All employees shall be oriented to the plan and their responsibilities in carrying out the plan. The Emergency/Disaster plan may be invoked for the following:
*Natural Disaster Blizzards, Floods, Fires, etc.
*Civil Defense Disaster — War, Poisonous gas, Nuclear accident
*Disruption of Telephone — Strike, Transportation accident, Blackout, etc.
Response-Should a disaster occur during regular business hour. the director of nursing is responsible for putting the plan into effect. After 6 p.m. or weekends, the on call coordinator shall access patients in life threatening situations. Those whose lives are threatened, such as ventilator depend cases and bed confined persons living alone and bed confined person living alone, shall immediately arrange with staff, the police or fire department to dispatch assistance as soon as possible The director of nursing will notify the director. The director of nursing will work with the coordinator to begin identifying the location and availability of all staff. The coordinator shall contact staff by phone, if possible to instruct them where to report. All staff shall also be advised that they must phone the office to report their where about and availability. The coordinator shall maintain constant contact with director of nursing to advise them of the staff status and shall assign cases as directed by the nurse. Notifications shall be by priority as follows:

Priority 1 (Red):	Life threatening situations, such as those previously described.
Priority 2 (Yellow):	Persons living alone, handicapped persons and those dependent on the agency
Priority 3 (Green):	All others, be sure that on all charts are listed, telephone numbers for hospital, fire ·tment, patients physical, patients next of kin.

SPECIFIC DUTIES AND RESPONSIBILITIES

In order to comply with the Americans with Disabilities Act (ADA), each essential duty should be indicated with an "x" in the ADA box. A duty is essential if:
The position exists to perform that duty
It requires specialized skills and/or expertise
It can only be performed by a limited number of available employees.

ADA	RESPONSIBILITIES
X	Preparing and serving normal/therapeutic diets. Assisting patient with eating and monitors intake.
X	Assisting with bathing of patient in bed, tub and shower
X	Assisting with grooming, care of hair, including shampoo, shaving with electric razor only, and ordinary care of nails this means soaking and filing nails.
X	Assisting with care of teeth and mouth.
X	Assisting patient on and off bedpan, commode and toilet.
X	Assisting patient in transferring from bed to chair, to wheelchair and in walking with or without devices.
X	Assisting patient with dressing.
X	Assisting patient with self-administered, oral medications that have been ordered by the medical practitioner.
X	Taking temperature, pulse and respiration as directed
X	Use of special equipment i.e. Hoyer lift.
X	Assisting, as instructed with a home exercise program including passive range of motion, turning and positioning.
X	Reporting any change in patient's mental and physical condition or home situation to the nurse.
X	Making and changing bed/linens
X	Dusting and vacuuming the rooms the patient uses.
X	Tidying kitchen, dishwashing.
X	Tidying bedroom.
X	Tidying bathroom.
X	Patient's personal laundry; this may include necessary ironing and mending.
X	Provides a supportive environment and ongoing reality orientation to confused patients using appropriate interpersonal behavioral techniques
X	Assists with self-administered medications.
X	Take and record temperature, pulse and respiration.
X	Measure and record Intake and Output.
X	Reinforce sterile dressing.
X	Empty urinary or ostomy bag.
X	Cleanse catheter insertion site
X	Administer special skin care a directed.
X	Collect stool, sputum and urine specimens using appropriate teclhniques.
X	FUNCTIONS PERMISSIBLE FOR HOME HEALTH AIDES UNDER SPECIAL CIRCUMSTANCES: If no family member is present or capable of providing care for a specific patient, the nurse may with the approval of physician, teach and closely supervise the Aide in the following procedures.
X	Assist with changes of colostomy bag.
X	Reinforce dressing and change simple non-sterile dressing.
X	Assist in the use of devices geared to disability to aid in daily living.
X	Assist patient with prescribed exercises which the Home Health Aide has been taught ty appropriate professional personnel.
X	Apply prescribed ice cap or ice collar.
X	Perform simple urine test for sugar, acetone or albumen and record results.
X	Perform functions allowable as per: NY'S DOH Approved Scope of Practice.

THE PCA WILL NOT PERFORM THE FOLLOWING FUNCTIONS UNDER ANY CIRCUMSTANCES:

Foley catheter irrigation.
Apply a sterile dressing.
Give enemas or remove impactions.
Perform gastric lavage or gavage.
Application of heat in any form.

CUSTOMER SERVICE/INTERPERSONAL SKILLS

1. Assists other employees where needed.
2. Responsible and cooperative with patient/families, supervisors, fellow employees.
3. Maintains friendly working atmosphere.
4. Maintain appropriate attitude.
5. Maintain appropriate appearance.
6. Accepts constructive criticism as evidenced by appropriate changed in behavior.
7. Utilizes established channels of communication.
8. Recognizes, accepts and respects people as individuals.
9. Recognizes limitations and seeks assistance appropriately.

SPECIALIZED SKILLS AND TECHNICAL COMPRETENCIES

Ability to apply prosthetic devices
Ability to take and record TPR and measure I&O
Ability to reinforce sterile dressing and change non-sterile dressing.
Ability to follow the instructions related to exercise and positioning.
Ability to safely use the Hoyer lifts.
Ability to care for urinary, ostomy and Foley catheters.
Ability to apply warm or cold compress, ace bandage and elastic stockings.

PHYSICAL DEMAND

The physical demands described here are representative of those that must lie and by an employee to successful perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform essential functions, Check one physical requirement which applies to this position:

MEDIUM WORK: Exerting up to 50 pounds of force occasionally and/or up to 20 pounds of force frequently and/or up to 10 pounds of force constantly to move objects.

- ☐ I certify that I have read and understood the job description that I am applying for the employer's company rules and policies.
- ☐ I acknowledge that I am responsible for knowing and adhering to those guidelines contained therein while I am employed with above agency.
- ☐ I certify that have been oriented on the "policies and procedures for maintaining confidentiality of HIV related information" by the director of clinical service and under its contents

- ☐ I acknowledge that I am responsible for knowing and adhering to those guidelines contained therein while I am employed with above agency.

- ☐ I certify that have read and understood the all the responsibilities and special skills required for the job that I am applying

- ☐ I acknowledge that I am responsible for knowing and adhering to those guidelines contained therein while I am employed with above agency

Applicant Signature: _____ Date: _____

PATIENT'S RIGHTS

1. Be informed of your rights both verbally and in writing at the time of admission and prior to the initiation of care.
2. Receive competent, individualized care and service from BIG HEART HOME CARE staff regardless of age, race, color, national origin, religion, sex, disease, disability or any other category protected by law or decisions regarding advance directives.
3. Be treated with dignity, courtesy, consideration, respect and have your property treated with respect.
4. Be informed verbally and in writing of the services available and related charges, as they apply to the primary insurance. Other payers and self-pay coverage before care is initiated. To be informed of any changes in the sources of payment and your financial responsibility as soon as possible by no later than thirty (30) calendar days after BIG HEART HOME CARE becomes aware of the change.
5. Be informed both orally and in writing, in advance of the Plan of Care, of any changes in Plan of Care, and to be included in the planning of care before treatment begins; be informed of all treatment prescribed, when and how services will be provided, and the names and functions of any person and affiliated program providing care and services, including photo identification of agency staff and participate in the development of the discharge plan.
6. Participate in the planning of your care and be advised in advance of any changes to the plan of care.
7. Refuse care and treatment after being fully informed of and understanding the consequences of such actions and initiate an Advance Directive. "Living Will", durable power of attorney and other directives about your care consistent with applicable law and regulations. Refuse to participate in research or experimental treatment.
8. To appropriate assessment of pain and management of his/her pain.
9. Receive information regarding community resources and to be informed of any financial relationship between BIG HEART HOME CARE and other providers to which you may be referred to by the agency.
10. Be informed of the procedures for submitting patient complaints, voice complaints and recommend changes in the policies and services to Director of Patient Services by calling the following telephone number (347) 5424150. If dissatisfied with the outcome, you may also submit the complaint to the New York State Department of Health or any outside representative of the patient's choice. The expression of such complaints by the patient or patient designee shall be free from interference, coercion, discrimination or reprisal.
11. Express complaints about the care and services provided or not provided and complaints concerning lack of respect for property by personnel furnishing services on behalf of BIG HEART HOME CARE and to expect the agency to investigate such complaints within 15 days of receipt of complaint. Also, if dissatisfied with the outcome, may submit an appeal to the agency's governing authority which will be reviewed within 30 days of receipt of appeal request.
12. Receive timely notice of impending discharge or transfer to another agency or to a different level or care and to be advised of the consequences and alternatives to such transfers.
13. Privacy, including confidential treatment of records and access to your records on request. Information will not be released without your written consent except for those instances required by law, regulation or third patty reimbursement.
14. In the situation when the patient lacks capacity to exercise these rights, the rights shall be exercised by an individual, guarding or entity legally authorized to represent the patient.

☐ I certify that I have read and understood the patient's rights.

☐ I acknowledge that I am responsible for knowing and adhering to those guidelines contained therein while I am employed with above agency.

Applicant Signature: _____ Date: _____

AGREEMENT OF STANDARDS/EMPLOYMENT ACKNOWLEDGMENT

I, _____ understand that this Agency is a temporary employment service and cannot guarantee any number of hours in any given week. Even if I work full week, I cannot expect the same number of hours in the following weeks or months, I have been fully advised that after I am employed, I will be terminated if I violate any of the following standards:

1. Verbal and/or physical abuse of any client or employer.
2. Accept an assignment and not notify this Agency that I will not be going to work or not appearing for work on a current assignment without notifying this agency' after 3 attempts.
3. Excessive lateness or absenteeism; that is, more than a two (2) times within a one-month period.
4. Violation of the Confidentiality Policy.
5. Misrepresent reference sources.
6. Misrepresent time worked on an assignment.
7. Take any or money that belongs to a client of this agency, accept money or gifts from clients, or make long-distance phone calls without permission.
8. Work directly for a client whose services originated with this agency.
9. Use of alcohol or drugs of any kind before or during wok schedule.
10. Refusal to comply with assigned duties or dress code on assignment; unsatisfactory job performance.
11. Appear for work accompanied by any other person i.e. take children to work with you.
12. Leave an assignment before scheduled time unless approved by the supervisor.
13. Lack of cooperation.
14. Violation of "Policies for Caregiver" in the Employee Policy Handbook.
15. Failure to provide any documentation requested by the Human Resources or any Agency representative.

If I am currently not working on an assignment for this agency I will call this agency each week with the times I am available for assignment. I understand that if I do not call with my availability each week, I will be considered voluntarily unavailable for assignment effective the day following any last assignment.

☐ I hereby agree that, for a period of 90 days after termination of my employment for any reason, I will not accept employment directly or indirectly, by or from any client of this agency for whom I performed services while working for this agency.

☐ I hereby acknowledge that I understand this agency's Agreement of Standards, and I received a copy of due agency's Agreement of Standards which states grounds for termination.

☐ I have carefully read and fully understood Big Heart Home Care terms and conditions. I understand that I must comply with the standards and policies set out by Big Heart Home Care at all times.

☐ I have received a copy of the policy

☐ I have received my photo identification card and will wear it at all times during my duty hours. I also agree to surrender my photo identification card upon termination of employment.

Applicant Signature: _____ Date: _____

DO NOT RIGHT BELOW THIS LINE

Received copy of the policy: ( ) Yes ( ) No Date: _____
Received the ID card: ( ) Yes ( ) No Date: _____

Authorized Signature: _____ Date: _____

WHISTLEBLOWER

Name: _____ Date: _____

Consider each of the following situations. Decide if a violation of privacy or confidentiality has occurred or needs to occur

Circle N if no breach has occurred or should occur. Circle Y if a breach has occurred and/or you must take action.

1. A friend tells you she is going cut on a date with a co-worker and asks you to keep it quiet. Dating other employees is against company policy at her work.
   ( ) Yes ( ) No

2. An elderly client confides she is contemplating suicide. She states, "I'm going to start saving my sleeping pills."
   ( ) Yes ( ) No

3. You are caring for a patient that used to be your elementary teacher. You call your friends and tell them that you are caring for your former teacher and discuss her medical situation.
   ( ) Yes ( ) No

4. You are caring for a patient and he demands that you buy him a bottle of whiskey at the store.
   ( ) Yes ( ) No

5. During your break time, a co-worker calls and asks you to tell her about Mr. Smith, a patient whom you have been caring for. You describe all the tattoos on his arm to your co-worker.
   ( ) Yes ( ) No

6. At home after work you empty your uniform pockets on the dresser and jump into the shower. Later, your husband asks you about your patient. He specifically mentions information that was in your notes.
   ( ) Yes ( ) No

7. You are assigned to take care of a male patient. The patient instructs you to wear short shorts and a sleeveless shirt.
   ( ) Yes ( ) No

8. A Pharmaceutical company representative calls the patient's home to drop off drug literature and free drug samples. He asks you if your patient takes prescription medication for hypertension (high blood pressure). You provide him the information he requests in exchange for one years free medication for yourself.
   ( ) Yes ( ) No

DO NOT RIGHT BELOW THIS LINE

Number of correct numbers _____

Approved ( ) Yes ( ) No

Authorized Signature: _____ Date: _____

HEPATITIS B VACCINATION CONSENT/DECLINATION

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

☐ Request that I receive the Hepatitis B Vaccine. I have been informed that the safety of receiving the Hepatitis B Vaccine during pregnancy has not been established. Nor do I intend to get pregnant within the next six (6) months while I am receiving the vaccine and for three (3) months after vaccination. (Total nine (9) months). Should I become pregnant, I understand that my vaccination series will be suspended and I will have to resume vaccination after my pregnancy is complete. (Females initials here: _____

☐ Refuse the Hepatitis B vaccine and hold harmless in the Agency. I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B virus (HPV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B Vaccine, at no charge to myself However, I understand that by declining the vaccine, I continue to have occupational exposure to blood or other potentially infectious materials and want to be vaccinated with the Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

☐ Provide written proof of immunity (attach supportive documents).
☐ Provide written proof of previous vaccination (attach supportive documents).
☐ Provide written proof of medical contradiction (attach supportive documents).

Applicant Signature: _____ Date: _____

EMPLOYEE ACCEPTANCE OF A DRUG-FREE WORKPLACE
PERMISSION FOR CRIMINAL BACKGROUND CHECK

As an employee of BIG HEART HOME CARE, I am aware that the manufacture, distribution, dispensing, possession, or' use of a controlled substance is prohibited in the work place. This agency requires a criminal background check to be performed by this state's State Police, and a negative drug screen as a condition for employment for all employees.

☐ I agree to abide by these conditions and to notify my employer of any criminal activities observed by me. I am also aware that violation of this policy will result in my termination of employment and possible conviction per New York Law.
☐ I understand that I must obtain a drug screen at an agency approved laboratory within one week of my orientation.
☐ I grant permission to this Agency to conduct a background check on me, the undersigned, through the State Police. I understand that failure to have an acceptable record may cause for immediate termination of employment.

My signature authorities this agency to release the results of the background check and drug screen and other related health screening to contracted facilities.

Applicant Signature: _____ Date: _____

DO NOT RIGHT BELOW THIS LINE

Authorized 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

2024

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.)

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 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 (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (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):

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

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

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. 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)

NEW YORK STATE | Department of Labor

Notice and Acknowledgement of Pay Rate and Payday Under Section 195.1 of the New York State Labor Law for Home Care Aides Wage Parity and Other Jobs

1. Employer Information

Name:

Doing Business As (DBA) Name(s):

FEIN (optional):

Physical Address:

Mailing Address:

Phone:

2. Notice given:

☐ At hiring

☐ Before a change in pay rate(s), allowances claimed or payday

Note: Live-in employees must be paid at least 13 hours for each 24 hour period, provided they receive 8 hours of sleep, with five hours of uninterrupted sleep and 3 hours off for meals. If an employee does not receive 5 hours of uninterrupted sleep, the employee must be paid for all 8 hours. If the employee does not receive meal periods free from duty, the employee must be paid for all 3 hours designated for meals.

3. Employee's Rate(s) of Pay for Each Type of Work Shift:

$_____ per hour for _____
$_____ per hour for _____
$_____ per hour for _____

3a. Wage Parity Rates:

$_____ per hour for regular wage
$_____ per hour for additional wage
$_____ per hour for supplemental wages*

4. Allowances:

☐ None
☐ Tips _____ per hour
☐ Meals _____ per meal
☐ Lodging _____
☐ Other _____

5. Regular Payday: _____

6. Pay is:

☐ Weekly
☐ Bi-weekly
☐ Other: _____

7. Overtime Pay Rate(s) for each type of work or shift:

Single Pay Rate: $_____ per hour
This must be at least 1½ times the worker's regular rate with few exceptions.

Wage Parity Pay Rate: $_____ per hour
This must be at least 1½ times the worker's regular rate with few exceptions.

Multiple Pay Rates: $_____ per hour
This must be at least 1½ times the worker's Weighted average of the multiple rates of pay for the week, with few exceptions.

8. Employee Acknowledgement:
On this date, I have been notified of my pay rate, overtime rate (if eligible), allowances, supplements and designated payday. I told my employer what my primary language is.

Check one:

☐ I have been given this pay notice in English, because it is my primary language.

☐ My primary language is _____. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

_____
Print Employee Name

_____
Employee Signature

_____
Date

_____
Preparer's Name and Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

Please note: It is unlawful for an employee with protected class status to be paid less than an employee without protected class status, if they are performing substantially equal work. Employers also may not prohibit employees from discussing wages with their co-workers.

*Attach Wage Parity supplement notification page 2.

LS 62 Notice to Wage Parity Home Care Aides - (cont'd)
Benefit Portion of Minimum Rate of Home Care Aide Total Compensation

	Hourly Rate	Type of Supplement	Name & Address of Provider	Agreement/ Plan Information
Supplement Number	*$ XXX*	*(Pension, Welfare, or Other)*	*Insert Name and Address of Company or Organization Providing Benefit*	*Identify plan or agreement that creates the benefit, e.g., Union Local No. 1 Collective Bargaining Agreement or Insurance Company X Benefit Plan*
Supplement Number 1				
Supplement Number 2				
Supplement Number 3				

**If wage supplements are paid as a single payment owed to multiple Taft-Hartley multiemployer plans, list only the following: (1) the total paid for the supplement or benefit package; (2) the types of benefits included in the package, e.g., pension, health and welfare, or other; (3) the name and address of the entity to whom payment is sent; and (4) the relevant CBA or letter of assent as the agreement.*

List any additional benefits and attach listing to this document.

Copies of the above listed agreements or summaries may be obtained by:

_____

Employee Acknowledgement:

On this day I have been notified of my pay rate, overtime rate, allowances, supplements/benefits, and designated payday provided on this form (LS 62) attached and this addendum on the date given below.

My primary language is _____. I have been given this notice in my primary language ☐ Yes ☐ No.

Employee Name (Print): _____

Employee Signature: _____ Date Signed: _____

Preparer's Name and Title: _____

NEW YORK STATE DEPARTMENT OF HEALTH

Criminal History Record Check

NEW YORK STATE | Department of Health

DOH CHRC form 102: Acknowledgement and Consent for Fingerprinting and Disclosure of Criminal History Record Information

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

Last Name | First Name | Middle Initial | Maiden Name

Date of Birth (mm/dd/yyyy) | Alias/AKA | Mother's Maiden Name

Mailing Address (street) | City | State | ZIP Code

SECTION 2 – ATTESTATION

1.	I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).
2.	I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
3.	I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary. In accordance with applicable laws, DOH will furnish appropriate summary information to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law. I have been informed that upon receiving notification from DCJS that there is a subsequent pending criminal action or proceeding or conviction, the DOH shall promptly notify an authorized person(s) of a provider of the additional allegation or new conviction.
4.	I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.
5.	I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI. If I believe an error has been made by DCJS for any New York State conviction/charge or the FBI for a non-New York State conviction/charge, I understand that I should notify DCJS and/or the FBI to report and request correction of this error to the addresses below.
	NYS Division of Criminal Justice Services Criminal History Bureau Record Review Unit-5th Floor 4 Tower Place, Albany, NY 12203 (518) 485-7675 — Federal Bureau of Investigation Criminal Justice Information Services (CJIS) Division 1000 Custer Hollow Road, Clarksburg, WV 26306 (304) 625-5590
6.	I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.
7.	I certify to the best of my knowledge and belief that I (check as appropriate): ◯ Have ◯ Have not been convicted of a crime in New York State or any other jurisdiction ◯ Do ◯ Do not have a final finding of patient or resident abuse If you checked either "Have" and/or "Do", please provide a brief explanation. (Optional)
8.	My current mailing or home address is indicated in Section 1 of this form.
9.	I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the re-disclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency in accordance with applicable laws. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own.

Applicant Signature: | Date: ☐☐/☐☐/☐☐☐☐

Name and Signature of Parent or Legal Guardian: (if subject individual is under 18 years of age) | Date: ☐☐/☐☐/☐☐☐☐

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name: | Operating License Number (PFI):

Print Name of Authorized Person: | Title:

Signature of Authorized Person: | Date: ☐☐/☐☐/☐☐☐☐

This form is to be retained by the agency. Do not forward to the DOH CHRC

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

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

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

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

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

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

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

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

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

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

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

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

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

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

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

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

Additional Information

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

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

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

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

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

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

BIG HEART HOME CARE
1302 Kings Hwy, 3rd floor, Brooklyn, NY 11229
Tel.: 347.542.4050 1 Fax: 347.542.4152

PRE-EMPLOYMENT HEALTH ASSESSMENT

(To be completed by prospective Employee)

Name: _____ Date of Birth: _____
Address:_____ Gender: ___M ___F
Phone #:_____ Last 4 digit of SSN:_____

PAST MEDICAL HISTORY

	Yes	No		Yes	No
Arthritis	___	___	Hearing Loss	___	___
Asthma	___	___	Hip Pain	___	___
Back Pain	___	___	Kidney Disease	___	___
Blood Pressure (HTN)	___	___	Knee Pain	___	___
Breast Cancer	___	___	Lung Disease	___	___
Cholesterol	___	___	Memory Loss	___	___
Cold and Flu	___	___	Neck Pain	___	___
Colon Cancer	___	___	Osteoporosis	___	___
Depression	___	___	Persistent Sores or Lumps	___	___
Diabetes	___	___	Prostate Cancer	___	___
Digestive Disorder	___	___	Sleeping Disorder	___	___
Epilepsy	___	___	Stress	___	___
Fatigue and Low Energy	___	___	Thyroid Disorder	___	___
Generalized Pain	___	___	Tuberculosis	___	___
Headaches (Migraine)	___	___	Weight Gain/Loss	___	___
Hand Pain	___	___	Other _____		

Have you ever:	Yes	No
Suffered from hearing problems or hearing loss	___	___
Suffered from visual problems or eye diseases	___	___
Had any serious/major surgery	___	___
Had back problems, back pain or back injuries	___	___
Had foot problems	___	___
Been a patient in a hospital for any reason	___	___

If YES, please complete the following

	NAME OR HOSPITAL	CONDITION TREATED FOR	DATES	DATES
1.				
2.				
3.				

	Yes	No	
Do you smoke CIGAREITES?	___	___	If YES - How many per day? _____How many years?_____
Do you drink ALCOHOL?	___	___	If YES - How many days per week?_____

Are you taking prescribed or over the counter medications, herbal product, vitamins, or supplements?

_____

_____

_____

MALES ONLY:	Yes	No	Circle if applicable
Have you now or have you ever had a HERNIA or RUPTURE A HERNIA?	___	___	
Have you ever had a Sexually Transmitted Disease?	___	___	Gonorrhea, Syphilis, Chlamydia
Have you ever had problems with your testicles (surgery, infection, injury)?	___	___	

FEMALES ONLY:	YES	NO	Circle if applicable
Have you nor or have you ever had any problems with your breasts (lumps, tumors, surgery)?	___	___	
Are you now or have you ever been pregnant?	___	___	
Have you ever had a Sexually Transmitted Disease?	___	___	Gonorrhea, Syphilis

I have read the above and declare that I am free from any health impairment which can be a potential risk to the patient or which might interfere with the performance of my duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances that may alter my behavior.

Signature (Firma): _____ Date (Fecha): _____

BIG HEART HOME CARE
INITIAL ORIENTATION

Name: _____ SS# _____

Title: _____

	Initials
1. Welcome to Big Heart Home Care	
A. Organization overview	_____
2. Employment/Management policies	
a. Compliance Requirements	_____
b. Meetings, Case Conferences & In-Service Requirements	_____
c. Job Description	_____
d. Employee Statement of Confidentiality	_____
e. Personnel Policy	_____
f. Privacy Policy	_____
g. Attendance, Punctuality & Cancellation Policy	_____
h. Availability	_____
i. Performance Evaluations	_____
j. Code of Conduct	_____
k. Disciplinary Action & Termination	_____
l. Emergency & Disaster Planning, Fire Safety	_____
m. Safety in the work environment	_____
n. Injuries: Reporting Incidents & Accidents	_____
3. Patient Care Management Policies	
a. Communication Skills	_____
b. The on-Call process	_____
c. In-Home Folder	_____
d. Personal Care Plan & Supervisory Visits	_____
e. Patient Emergencies in the Home	_____
f. Death in the Home Guidelines	_____
4. In Service & Video	
a. Patient Confidentiality — HIPPA/HIV/OSHA	_____
b. Infection Control & Blood Borne Pathogens — Hand Washing	_____
c. Home & Fire Safety	_____
d. Caregiver at Home: Professional Boundaries	_____
e. Emergency and Disaster Plan	_____
5. Documentation: Professional & Paraprofessional workshops	
a. HHA Activity Note/Time Sheet	_____
b. Clinical Documentation Workshop	_____
c. Vendor Documentation Workshop	_____

I have read my job description and understand that I will be evaluated based on the performance criteria in my job description. I acknowledge having completed all of the in-service curriculum.

_____ _____

Employee Signature Date

_____ _____

Instructor's Signature

BIG HEART HOME CARE

HHA/PCA COMPETENCY TEST
ANSWER SHEET

Name: _____ Date: _____

1. A B C D	21. A B C D	41. A B C D
2. A B C D	22. A B C D	42. A B C D
3. A B C D	23. A B C D	43. A B C D
4. A B C D	24. A B C D	44. A B C D
5. A B C D	25. A B C D	45. A B C D
6. A B C D	26. A B C D	46. A B C D
7. A B C D	27. A B C D	47. A B C D
8. A B C D	28. A B C D	48. A B C D
9. A B C D	29. A B C D	49. A B C D
10. A B C D	30. A B C D	50. A B C D
11. A B C D	31. A B C D	51. A B C D
12. A B C D	32. A B C D	52. A B C D
13. A B C D	33. A B C D	53. A B C D
14. A B C D	34. A B C D	54. A B C D
15. A B C D	35. A B C D	55. A B C D
16. A B C D	36. A B C D	56. A B C D
17. A B C D	37. A B C D	57. A B C D
18. A B C D	38. A B C D	58. A B C D
19. A B C D	39. A B C D	59. A B C D
20. A B C D	40. A B C D	60. A B C D

_____ _____ _____

Name of RN Administering Test | RN Signature | Date

BIG HEART HOME CARE

CONFIDENTIALITY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL AND DRUG AND ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

General Information

Information about your treatment and care, including payment for care, is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996 ("HIPAA")* and the Confidentiality Law**. Under these laws the program may not say to a person outside of the program that you attend the program, nor may the program disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by the federal laws referenced below.

The program must obtain your written consent before it can disclose information about you for payment purposes. For example, the program must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before the program can share information for treatment purposes or for health care operations. However, federal law permits the program to disclose information in the following circumstances without your written permission:

1. To program staff for the purposes of providing treatment and maintaining the clinical record;
2. Pursuant to an agreement with a business associate (e.g. Clinical laboratories, pharmacy, record storage services, billing services);
3. For research, audit or evaluations (e.g. State licensing review, accreditation, program data reporting as required by the State and/or Federal government);
4. To report a crime committed on the program's premises or against program personnel;
5. To medical personnel in a medical/psychiatric emergency ;
6. To appropriate authorities to report suspected child abuse or neglect;
7. To report certain infectious illnesses as required by state law;
8. As allowed by a court order.

Before the program can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing. (NOTE: Revoking a consent to disclose information to a court, probation department, parole office, etc. may violate an agreement that you have with that organization. Such a violation may result in legal consequences for you.)

Your Rights

• Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health and treatment information. The program is not required to agree to any restrictions that you request, but if it does agree with them, it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.
• You have the right to request that we communicate with you by alternative means or at an alternative location (e.g. another address). The program will accommodate such requests that are reasonable and will not request an explanation from you.
• Under HIPAA you also have the right to inspect and copy your own health and treatment information maintained by the program, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.
• Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in the program's records, and to request and receive an accounting of disclosures of your health related information made by the program during the six (6) years prior to your request.
• If your request to any of the above is denied, you have the right to request a review of the denial by the program Administrator.
• To make any of the above requests, you must fill out the appropriate form that will be provided by the program.

• You also have the right to receive a paper copy of this notice.

The Use of Your Information at the program

In order to provide you with the best care, the program will use your health and treatment information in the following ways:

• Communication among program staff (including students or other interns) for the purposes of treatment needs, treatment planning, progress reporting and review, staff supervision, incident reporting, medication administration, billing operations, medical record maintenance, discharge planning, and other treatment related processes.

• Communication with Business Associates such as clinical laboratories (blood work, urinalysis), food service (special dietary needs), agencies that provide on-site services (lectures, group therapy) long term record storage.

• Reporting data to the NYS OASAS Client Data System.

The Program's Duties

The program is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. The program is required by law to abide by the terms of this notice. The program reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. The program will provide current patients with an updated notice, and will provide affected former patients with new notices when substantive changes are made in the notice.

State of New York
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

Complaints and Reporting Violations

Patients have the right to make a complaint about the Confidentiality and Privacy of their Health Information. The patient may complete a Privacy Complaint form (on reverse side of this form) and submit the form to the:

• ATC Administrator;

• Bureau of Addictions Treatment Centers, 1450 Western Avenue, Albany, NY 12203; or

• OASAS Privacy Official. , 1450 Western Avenue, Albany, NY 12203.

The complaint will be reviewed by an appropriate individual, based on the nature of the complaint. That individual will complete the Privacy Complaint Resolution form. Copies will be forwarded to OASAS Privacy Official, 1450 Western Avenue, Albany, NY 12203.

The patient may also register a complaint with the:

Office for Civil Rights
U.S. Department of Health and Human Services,
Jacob Javits Federal Building
26 Federal Plaza--Suite 3313
New York, New York, 10278
Voice Phone (212) 264-3313.
FAX (212) 264-3039.
TDD (212) 264-2355
OCR Hotlines-Voice: 1-800-368-1019

You will not be retaliated against for filing such a complaint.

Violation of the Confidentiality law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

I, _____ have received a copy of the Confidentiality Notice, and it has been explained to me.

_____

Signature Date

_____

Parent/Guardian Signature (if necessary) Date

Consumer Affairs

Bill de Blasio
Mayor

Lorelei Salas
Commissioner

NOTICE OF EMPLOYEE RIGHTS

Under New York City's Earned Safe and Sick Time Act (Paid Safe and Sick Leave Law), certain employees have a right to safe and sick leave. Go to nyc.gov/PaidSickLeave to learn which employees are covered by the law.

Employees who work for employers with five or more employees who work more than 80 hours a calendar year in New York City have a right to *paid* safe and sick leave. Employees who work for employers with fewer than five employees have a right to *unpaid* safe and sick leave.

Employees who work for employers who must provide safe and sick leave must receive this written notice from their employer when they begin employment or by June 4, 2018, whichever is later.

YOU HAVE A RIGHT TO SAFE LEAVE, which you can use to seek assistance or take other safety measures if you or a family member may be the victim of any act or threat of domestic violence or unwanted sexual contact, stalking, or human trafficking.

YOU HAVE A RIGHT TO SICK LEAVE, which you can use for the care and treatment of yourself or a family member.

AMOUNT OF SAFE AND SICK LEAVE:

- Your employer must provide up to a total of 40 hours of safe and sick leave every calendar year. You may use any earned leave for either safe or sick leave purposes. Your employer's calendar year is:

  Start of Calendar Year: _____ End of Calendar Year: _____

RATE OF ACCRUAL:

- You accrue safe and sick leave at the rate of one hour for every 30 hours worked, up to a maximum of 40 hours of safe and sick leave per calendar year.

DATE ACCRUAL BEGINS:

You begin to accrue safe and sick leave on April 1, 2014 or on your first day of employment, whichever is later.

Exception: If you are covered by a collective bargaining agreement that was in effect on April 1, 2014, you begin to accrue safe and sick leave under City law beginning on the date that the agreement expires.

DATE SAFE AND SICK LEAVE IS AVAILABLE FOR USE:

- You could begin using sick leave on July 30, 2014 or 120 days after you begin employment, whichever is later.
- You could begin using safe leave on May 5, 2018 or 120 days after you begin employment, whichever is later.

ACCEPTABLE REASONS TO USE SAFE AND SICK LEAVE:

You can use safe and sick leave to take time off from work when:

- You have a mental or physical illness, injury, or health condition; you need to get a medical diagnosis, care, or treatment of your mental or physical illness, injury, or condition; you need to get preventive medical care.
- You must care for a family member who needs medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition, or who needs preventive medical care.
- Your employer's business closes due to a public health emergency or you need to care for a child whose school or child care provider closed due to a public health emergency.
- You or a family member may be the victim of any act or threat of domestic violence or unwanted sexual contact, stalking, or human trafficking and you need to take actions necessary to restore the physical, psychological, or economic health or safety of you or your family members or to protect those who associate or work with you, including to:
  - Obtain services from a domestic violence shelter, rape crisis center, or other services program.
  - Participate in safety planning, relocate, or take other actions to protect your safety or that of your family members, including enrolling children in a new school.
  - Meet with an attorney or social service provider to obtain information and advice related to custody; visitation; matrimonial issues; orders of protection; immigration; housing; discrimination in employment, housing, or consumer credit.
  - File a domestic incident report with law enforcement or meet with a district attorney's office.

More >

FAMILY MEMBERS:
The law recognizes the following individuals as "family members:"

- Any individual whose close association with the employee is the equivalent of family
- Child (biological, adopted, or foster child; legal ward; child of an employee standing *in loco parentis*)
- Grandchild
- Spouse
- Domestic Partner
- Parent
- Grandparent
- Child or Parent of an employee's spouse or domestic partner
- Sibling (including a half, adopted, or step sibling)
- Any other individual related by blood to the employee

ADVANCE NOTICE:
If the need is foreseeable, your employer can require up to seven days advance notice of your intention to use safe or sick leave. If the need is unforeseeable, your employer may require you to give notice as soon as practicable.

DOCUMENTATION:
Your employer can require documentation if you use more than three consecutive workdays as safe or sick leave. The Paid Safe and Sick Leave Law prohibits employers from requiring the health care provider to specify the medical reason for sick leave or requiring safe leave documentation to specify the details of any act or threat of domestic violence or unwanted sexual contact, stalking, or human trafficking. Disclosure may be required by other laws.

UNUSED SAFE AND SICK LEAVE:
Up to 40 hours of unused safe and sick leave can be carried over to the next calendar year. However, your employer is only required to let you use up to 40 hours of safe and sick leave per calendar year.

YOU HAVE A RIGHT TO BE FREE FROM RETALIATION FROM YOUR EMPLOYER FOR USING SAFE AND SICK LEAVE.

Your employer cannot retaliate against you for:

- Requesting and using safe and sick leave.
- Filing a complaint for alleged violations of the law with DCA.
- Communicating with any person, including coworkers, about any violation of the law.
- Participating in a court proceeding regarding an alleged violation of the law.
- Informing another person of that person's potential rights.

Retaliation includes any threat, discipline, discharge, demotion, suspension, or reduction in your hours, or any other adverse employment action against you for exercising or attempting to exercise any right guaranteed under the law.

YOU HAVE A RIGHT TO FILE A COMPLAINT.

You can file a complaint with DCA. To get the complaint form, go online to **nyc.gov/PaidSickLeave** or contact 311 (212-NEW-YORK outside NYC).

DCA will conduct an investigation and try to resolve your complaint. DCA will keep your identity confidential unless disclosure is necessary to conduct the investigation, resolve the complaint, or is required by law.

Keep a copy of this notice and all documents that show your amount of safe and sick leave accrual and use.

Note: The Earned Safe and Sick Time Act sets the minimum requirements for safe and sick leave. Your employer's leave policies may already meet or exceed the requirements of the law.

You have a right to be given this notice in English and, if available on the DCA website, your primary language.

For more information, including Frequently Asked Questions, go to **nyc.gov/PaidSickLeave** or call **311** and ask for information about Paid Safe and Sick Leave.

NAME: _____

SIGNATURE: _____ DATE: _____

STOP SEXUAL HARASSMENT ACT NOTICE

All employers are required to provide written notice of employees' rights under the Human Rights Law both in the form of a displayed poster **and** as an information sheet distributed to individual employees at the time of hire. This document satisfies the poster requirement.

The NYC Human Rights Law

The NYC Human Rights Law, one of the strongest anti-discrimination laws in the nation, protects all individuals against discrimination based on gender, which includes sexual harassment in the workplace, in housing, and in public accommodations like stores and restaurants. Violators can be held accountable with civil penalties of up to $250,000 in the case of a willful violation. The Commission can also assess emotional distress damages and other remedies to the victim, require the violator to undergo training, and mandate other remedies such as community service.

Sexual Harassment Under the Law

Sexual harassment, a form of gender-based discrimination, is unwelcome verbal or physical behavior based on a person's gender.

Some Examples of Sexual Harassment

- unwelcome or inappropriate touching of employees or customers
- threatening or engaging in adverse action after someone refuses a sexual advance
- making lewd or sexual comments about an individual's appearance, body, or style of dress
- conditioning promotions or other opportunities on sexual favors
- displaying pornographic images, cartoons, or graffiti on computers, emails, cell phones, bulletin boards, etc.
- making sexist remarks or derogatory comments based on gender

Retaliation Is Prohibited Under the Law

It is a violation of the law for an employer to take action against you because you oppose or speak out against sexual harassment in the workplace. The NYC Human Rights Law prohibits employers from retaliating or discriminating "in any manner against any person" because that person opposed an unlawful discriminatory practice. Retaliation can manifest through direct actions, such as demotions or terminations, or more subtle behavior, such as an increased work load or being transferred to a less desirable location. The NYC Human Rights Law protects individuals against retaliation who have a good faith belief that their employer's conduct is illegal, even if it turns out that they were mistaken.

Report Sexual Harassment

If you have witnessed or experienced sexual harassment inform a manager, the equal employment opportunity officer at your workplace, or human resources as soon as possible.

Report sexual harassment to the NYC Commission on Human Rights. Call 718–722–3131 or visit NYC.gov/HumanRights to learn how to file a complaint or report discrimination. You can file a complaint anonymously.

State and Federal Government Resources

Sexual harassment is also unlawful under state and federal law, where statutes of limitations vary.

To file a complaint with the New York State Division of Human Rights, please visit the Division's website at **www.dhr.ny.gov**.

To file a charge with the U.S. Equal Employment Opportunity Commission (EEOC), please visit the EEOC's website at **www.eeoc.gov**.

Name_____

Signature_____ Date_____

YouTube

NYC Commission on Human Rights

BILL DE BLASIO
Mayor

CARMELYN P. MALALIS
Chair/Commissioner

BIG HEART
HOME CARE

We care for you from the bottom of our hearts

I hereby acknowledge that my employer, the Big Heart Home Care, has offered me the opportunity to enroll in health coverage under a qualifying health insurance plan. I understand that I am entitled to participate in the plan as long as I continue to satisfy any eligibility requirements and continue to pay any required premium contributions, all in accordance with plan terms and state and federal law.

After due consideration, I hereby knowingly and voluntarily elect to **DECLINE** this offer of coverage. I understand that I will not have another opportunity to enroll in coverage under the health plan until the next open enrollment period or stability period (if eligibility requirements are satisfied), absent a special enrollment opportunity as determined by the health plan and in accordance with all state and federal laws.

_____

Print Name

_____ _____

Signature Date

FACT-FINDING AND ISSUE RESOLUTION ("FAIR") PROGRAM AND ARBITRATION

1. **Overview of the FAIR Program**. The Agency values each employee and looks forward to good relations with and among all of its employees. Occasionally, however, disagreements may arise between you and the Agency or between employees in a context that involves the Agency. We believe that the resolution of such disagreements will be best accomplished by internal dispute resolution and, where that fails, by binding arbitration that is conducted by an arbitrator. For these reasons, the Agency has adopted this Fact-finding and Issue Resolution Program (the "FAIR Program").
2. **Effect of this Document**. By signing this agreement, you agree that all "Claims" (as defined below in paragraph 3) between "You" and the "Agency" (as defined below in paragraph 3) shall be resolved exclusively by the internal dispute resolution procedures and the binding arbitration procedures described in this document. The FAIR Program is an essential element of your employment and, for current employees, continued employment with the Agency. You indicate your agreement to be bound by the FAIR Program's terms and conditions by signing this document.
3. **What Does the FAIR Program Cover?**
   a. The FAIR Program applies to any and all Claims, regardless of when those claims arose or accrued or were first asserted. For avoidance of doubt, the provisions of this agreement apply to claims that accrued, arose, or were asserted before execution of this agreement and to claims that accrued, arose, or were asserted after execution of this agreement. The provisions of this agreement also apply to Claims that arose after your employment with the Agency ends
   b. The "Agency " means Big Heart Home Care LLC and its parents, subsidiaries, affiliates, predecessors, and successors, as well as each of their current and former owners, members, managers, shareholders, partners, directors, officers, employees, and agents.
   c. "You" and "Your" refers to you and any other person who may assert your rights.
   d. "Claim" includes any claim, dispute, allegation, controversy, or action between You and the Agency that in any way arises from, or relates to, Your employment with the Agency or the termination of Your employment with the Agency. A Claim encompasses, for example, any employment, labor, wage-and-hour, overtime, and compensation claims, including, without limitation, any Claim that may arise under the following laws:

   * Title VII of the Civil Rights Act
   * New York Public Health Law Section 3614-c, also known as Wage Parity Law
   * The Age Discrimination in Employment Act
   * Older Workers Benefit Protection Act
   * Americans with Disabilities Act
   * Fair Labor Standards Act of any state wage and hour laws, such as New York Labor Law
   * Domestic Workers Bill of Rights
   * Family and Medical Leave Act
   * Worker Adjustment and Retraining Notification Act
   * any state anti-discrimination, anti-retaliation, or whistleblower laws (including, without limitation, the New York State Human Rights Law and the New York State Whistleblower Law)
   * Any other federal, state, or local statute, regulation, or common-law doctrine regarding employment, employment discrimination, harassment, terms and conditions of employment, compensation, breach of contract, or defamation.
   * Any common law theories, such as tort, contract, or quasi-contract, including, but not limited to, claims of breach of an expressed or implied contract, tortious interference with contract or prospective business advantage, breach of the covenant of good faith and fair dealing, unjust enrichment, promissory estoppel detrimental reliance, retaliation, violation of public policy, invasion of privacy, nonphysical injury, personal injury or sickness or any other harm, wrongful or retaliatory discharge, fraud, defamation, slander, libel, false imprisonment, or negligent or intentional infliction of emotional distress
   * Disputes about the validity, enforceability, coverage or scope of the FAIR Program or any part thereof

The above list is not exclusive, and is only provided to illustrate examples of Claims. All Claims, whether listed above or not, must be resolved through the FAIR Program.

4. **Are any Claims excluded from the FAIR Program?** The term "Claim" does not include the following, which are for a court or an agency and not an arbitrator to decide:
   * claims for sexual harassment
   * claims for workers' compensation (except that claims for interference with or retaliation for filing a workers' compensation claim will be considered a Claim subject to arbitration under the FAIR Program)
   * claims for unemployment compensation benefits
   * claims for employee welfare benefits (e.g., medical, health, dental)
   * claims for retirement benefits under the Employee Retirement Income Security Act ("ERISA") (except that claims for interference with or retaliation for exercising protected rights under ERISA shall be considered Claims subject to arbitration under the FAIR Program)
   * unfair labor practice charges under the National Labor Relations Act

The FAIR Program also does not prevent You from pursuing a claim based on alleged violations of any applicable collective bargaining agreement grievance procedure. Claims that are independent of rights under the collective bargaining agreement and/or that can be resolved without interpreting the collective bargaining agreement are not excluded from the FAIR Program. For instance, a claim alleging a violation of New York Labor Law, the Fair Labor Standards Act, or any other federal or state law is subject to the FAIR Program.

The FAIR Program also does not prevent You from filing a charge, testifying, assisting, or otherwise participating in any investigation or proceeding conducted by the equal employment opportunity commission, or another government agency to the extent that You have a protected right to do so. But if You take such action in relation to a claim, controversy, or other dispute that would constitute a Claim and You have not fully pursued such dispute through the FAIR Program, the Agency may request the agency in question to defer its processing or investigation of such charge until the FAIR Program has been completed. Not with standing Your rights under this subsection, You agree that, to the maximum extent permitted by law, You may recover monetary relief with respect to a Claim only through the FAIR Program.

Further, the FAIR Program does not require the Agency to begin arbitration proceedings or initiate any other procedure before taking any action regarding Your employment with which You might disagree, such as coaching, counseling, warning, reprimand, suspension, investigation, discipline, demotion, changing Your days or hours of work, or termination.

5. **Can a Claim be Resolved in Court?** No. Under the FAIR Program, You and the Agency each waive your respective rights to have a Claim decided by a court, judge, jury and, where permitted by law, an administrative agency. **Instead, You and the Agency hereby agree that the internal dispute resolution and arbitration procedures set forth below are the sole and exclusive methods for resolving any and all Claims**
6. **Submitting a Claim Under FAIR Program?** If You believe that You have a Claim against the Agency, You should first give the Agency a chance to investigate and resolve the Claim before You file a demand for arbitration (the arbitration process is explained further below). You do not need to use any specific form to submit a Claim. Simply write a letter explaining Your Claim and the relief sought, and submit the Claim letter to the Administrator, Big Heart Home Health Care, 1302 Kings Highway, 3 Floor, Brooklyn, New York 11229. **If You do not receive a response from the Agency within 30 days of the date that You submitted Your letter, or You disagree with the response from the Agency, and You wish to pursue the Claim further, You must submit Your Claim exclusively to binding arbitration with the American Arbitration Association ("AAA") in accordance With the AAA's Employment Arbitration Rules and Mediation Procedures.**
7. **How Much Time do You Have to File a Claim?** An arbitration proceeding must be commenced within the time period prescribed by the statutes of limitations applicable to the Claim being asserted. For purposes of statute of limitations, an arbitration proceeding is deemed commenced when a demand for arbitration is filed with the AAA.

8. **How Does the Arbitration Process Begin?** To start the arbitration process, the party wishing to file a Claim must file a written demand in accordance with the rules of the AAA for starting the arbitration process. More information about the AAA may be obtained at www.adr.org or by calling 1.800.778.7879.
9. **How is the Arbitrator Selected?** Arbitrators will be selected by the parties in accordance with the AAA's Employment Arbitration Rules and Mediation Procedures. The arbitrator must be a licensed attorney or a retired judge selected from the AAA's Employment Arbitration Rules and Mediation Procedures Employment Dispute Resolution Roster, or a similar list if such list is unavailable. Unless the parties agree otherwise, the arbitrator must be a retired or former judge or a lawyer who has at least 5 years of experience with employment-related claims. No person may serve as an arbitrator unless that person has confirmed in writing that he or she is bound by and will adhere to the requirements of the FAIR Program
10. **Can an Attorney. Represent You?** Yes. Any party may be represented by an attorney. However, legal representation is not required and You may represent yourself.
11. **When and Where will the Arbitration Hearing Take Place?** The arbitration hearing will be conducted by the arbitrator in whatever manner will most expeditiously permit full presentation of evidence and arguments of the parties. The arbitrator will set the time, date, and place of the hearing, notice of which must be given to the parties at least 30 calendar days in advance, unless the parties agree otherwise. In the event the cannot be reasonably completed in one day, the arbitrator will schedule the hearing' to be continued on a mutually convenient date. Any arbitration hearing will take place within New York City, New York, unless the parties agree otherwise.
12. **What Rules and Law Apply to the Arbitration?** Arbitration under the FAIR Program will be conducted pursuant to the AAA's Employment Arbitration Rules and Mediation Procedures, except that under no circumstances will an arbitrator have the authority to hear or decide any Claim on a class, collective, or other group or representative basis. The arbitrator must apply the substantive law, including the applicable burdens of proof and persuasion, that would be applied by a court hearing the Claim in the venue the arbitration. The arbitrator may grant relief that could be granted by a court healing the Claim, including an award of attorneys' fees and costs.
13. **Can Claims be Heard on a Class, Representative, or Collective Basis? No, this is not permitted under any circumstances**. Notwithstanding anything to the contrary: (a) no arbitrator is permitted to hear or decide any Claim on a class, collective, or other group or representative basis; (b) all Claims between You and the Agency must be decided individually; and (c) the AAA's Supplementary Rules for Class Action Arbitration (and any similar rules) will not have any applicability to any Claim. This means that if You have a Claim, neither You nor the Agency will have the right, with respect to that Claim, to do any of the following in court or before an arbitrator: (a) pursue or obtain any relief from a class, collective, or other group or representative action; (b) act as a private attorney general; of (c.) join or consolidate a Claim with the Claim of any other person. Thus, the arbitrator shall have no authority or jurisdiction to process, conduct, or rule upon any class, collective, private attorney general, or other representative or group proceeding under any circumstances. If there is more than one Claim between You and the Agency, those Claims may be heard in a single arbitration hearing.
14. **Who Pays for the Arbitration?** The party claiming to be aggrieved is responsible for paying the applicable filing fee in effect and established by the AAA at the time the demand for arbitration is made. If You file the demand for arbitration and cannot obtain a waiver of the filing fee, You can ask the Agency to pay the filing fee. The Agency will review every such request in good faith and consider whether to cover all or part of such-filing fee. The arbitrator will charge a fee for his/her services and his/her costs. The Agency will pay the fees charged by the arbitrator if You bring a Claim against the Agency pursuant to this FAIR Program. Each party will be responsible for its own attorneys' fees, but the arbitrator may award either party reasonable attorneys' fees and costs in accordance with the applicable law
15. **Are the Parties Entitled to Discovery or Depositions?** Yes. All discovery will be governed by the AAA rules.
16. **Can You have Witnesses Testify at the Arbitration?** Yes. At the hearing, the parties will have the right to present proof through testimony and documentary evidence, and to cross-examine witnesses who testify at the hearing. The arbitrator will require all witnesses to testify under oath. The arbitrator(s) will also have the authority to decide whether any person who is not a witness may attend the hearing.
17. **The Arbitrator's Decision/Award** The arbitrator will issue his or her award promptly after the arbitration hearing concludes or post-hearing briefs are received. The arbitrator's award will set forth the factual and legal basis for the award, including his or her legal reasoning and contain a summary of the facts, the issues, the governing law applied, and the relief requested and awarded. It should also identify any other issues resolved and the disposition of any statutory claims. The arbitrator's award will be final and binding on the parties.
18. **How Long Does the FAIR Program Apply to You?** The FAIR Program will remain in effect and survive the cessation of Your employment relationship or affiliation with the Agency, regardless of the reason for such cessation.
19. **FAIR Program Opt-Out:** You will have seven (7) days after signing this agreement to revoke Your consent to the terms and conditions of the FAIR Program. Your consent must be revoked in writing, addressed to the Administrator, and received no later than close of business seven (7) calendar days from the date that You signed this FAIR Program agreement
20. **Miscellaneous Provisions Regarding the Fair Program:**

* Choice of Law. The FAIR Program and the terms of this agreement shall be governed by the Federal Arbitration Act ("FAA"). The parties acknowledge and agree that the FAIR Program evidences a transaction involving interstate commerce.
* Severability. If any part or provision of the FAIR Program or this agreement is held to be invalid, illegal, or unenforceable, such holding will not affect the legality, validity, or enforceability of the remaining parts, and each provision of the FAIR Program and this agreement will be valid, legal, and enforceable to the fullest extent permitted by law. However, in the event the provision prohibiting class, collective, or representative actions is found to be unlawful or unenforceable, then the entire FAIR Program and this agreement will be considered null and void.
* Notices. Any notice required to be given to You will be directed to Your last known address as reflected in the records of the Agency. Any notice required to be given to the Agency will be directed to the Administrator, Big Heart Home Health Care, 1302 Kings Highway, 3 Floor, Brooklyn, New York 11229
* Amendment. The Agency reserves the right to amend or terminate the FAIR Program. Such amendments may be made by providing notice to You, electronically or in writing, of such amendment or termination. Any amendments will be prospective only. If You continue to provide services after receiving notice of any amendment to or termination of the FAIR Program, You will be deemed to have consented to such amendment or termination
* Waiver. No waiver may be granted by either party, except in writing. No waiver of any provision of the FAIR Program will constitute a waiver of any Other provision of the FAIR Program (whether or not similar), nor will such waiver constitute a continuing waiver unless otherwise expressly provided in such writing.

By signing below, You confirm that and You have read and understand the terms and conditions of the FAIR Program, which require You to submit all Claims to binding arbitration on an individual basis

_____	_____
EMPLOYEE SIGNATURE	EMPLOYER SIGNATURE
_____	_____
PRINT EMPLOYEE NAME	PRINT NAME OF EMPLOYER REPRESENTATIVE
_____	_____
DATE	DATE

SLEEP & MEAL PERIOD POLICY FOR EMPLOYEES ON DUTY FOR 24 HOURS OR MORE

You will be paid for all hours worked. During each full 24-hour period during which you are required to be on duty, you agree that you will receive Bona Fide Meal Periods of up to 3 hours total and a Bona Fide Sleep Period of up to 8 hours, and that these hours (total of 1l) will not count as hours worked. All other hours during the course of such 24-hour period will be considered hours worked and you will be paid at the applicable rates for such work.
"Bona Fide Meal Periods" are meal periods (e.g., one each for breakfast, lunch, and dinner) that are uninterrupted, duty free, and at least 30 minutes in duration. While you may not leave the premises, you shall leave your work area during each of your Bona Fide Meal Periods. You are not required to eat with the patient during your meal period or take your meal period during the same time that the patient eats his/her meal.

"Bona Fide Sleep Periods" are regularly scheduled sleep periods, which include at least 5 consecutive hours that are not interrupted by a call to duty, in adequate sleeping facilities.

It is expected that you will only be required to work for 13 hours of the entire 24-hour shift you are assigned to be with the patient. It is expected that you will enjoy a total of at least 3 hours of Bona Fide Meal Periods as well as an 8-hour Bona Fide Sleep Period for each full 24-hour shift. Where you receive a total of at least 3 hours of Bona Fide Meal Periods as well as an 8-hour Bona Fide Sleep Period, you will be credited with 13 hours of work for the 24-hour shift.

"Adequate sleeping facilities" means that you have access to basic sleeping amenities (e.g., a bed and linens); enjoy reasonable standards of comfort (e.g., heat); and have access to basic bathroom and kitchen facilities, which may be shared (e.g., bathing and toilet facilities, refrigerator, stove, sink, utensils).

If you "live-in"| the home of the patient, "adequate sleeping facilities" means private quarters (i.e., a living and sleeping space that is separate from the patient or other employees) in a homelike environment (i.e., a space that includes facilities for cooking and eating, a bathroom, and a space for recreation (these additional facilities may be shared by you and the patient and/or other household members).

To ensure that you are paid for all hours you work, if you do not receive a total of at least 3 hours of Bona Fide Meal Periods and/or at least an 8-hour Bona Fide Sleep Period tor each full 24-hour shift, you must: (l) contact your coordinator as soon as possible following the conclusion of the shift at issue (generally, not later than within 24 hours following the end of the shift); and (b) complete a "Sleep and Meal Period Exception Certification Form" and return the form to your coordinator as soon as possible (generally, within 72 hours of the shift). A blank Sleep and Meal Period Exception Certification Form is set forth below and additional forms are available from any coordinator.
If you believe that you were not paid for all hours worked that you identified on a Sleep and Meal Period Exception Certification Form or otherwise, you must contact the Human Resources Department immediately and report the actual hours that you worked so that you can be compensated for all of your hours worked.

No employee will be subject to any reprisal or other adverse action for repotting missed or interrupted meal or sleep periods or for submitting a Sleep and Meal Period Exception Certification Form. But any employee who knowingly submits a false report or Sleep and Meal Period Exception Certification Form Will be subject to disciplinary action, up to and including termination of employment.

You "live in" if you reside at your worksite on a "permanent basis" (i.e., you stay there seven nights a week and have no other home of your own), or for "extended periods of time" (i.e. you work and sleep there five days a week (120 hours or more) or five consecutive days or nights (regardless of the total number of hours)

ACKNOWLEDGEMENT

I acknowledge receipt of the Agency's "Sleep and Meal Period Policy for Employees On Duty for 24 Hours or More," together with the Sleep and Meal Period Exception Certification Form, and by my signature below, I hereby agree to the terms and conditions set forth in this policy. I specifically and expressly agree that I will follow this policy and will notify the Human Services Department any time I work a shift of 24-hour or more and am unable to enjoy a total of at least 3 hours of Bona Fide Meal Periods and/or at least an 8-hour Bona Fide Sleep Period.

_____ _____

Signature Date

_____

Print name

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: Big Heart Home Care
Company EIN Number: 81-2859033

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

Upload To: www.wotc.com | Phone: 212-635-9500 | Fax: 212-994-2718 | Email: support@wotc.com

BIG HEART HOME CARE

1302 Kings Hwy, 3rd floor, Brooklyn, NY 11229 EMPLOYEE PHYSICAL EXAMINATION REPORT

Tel: 347.542.4150 Fax: 347 5424152

Name:	DOB:	Gender: M__ F__
Address:	Last 4-digit SS #:	Title:

PHYSICAL EXAMINATION

	NORMAL	ABNORAMAL		NORMAL	ABNORAMAL
HEAD/ENT			ABDOMEN		
EYES			EXTRIMITIES		
NECK			CARDIOVASCULAR		
THROAT			MUSCULOSKELETAL		
LUNGS			SKIN		
HEART			CENTRAL NERVOUS SYSTEM		

HT	WT	B/P:	PULSE:	RESP:	TEMP:

TUBERCULOSIS SKIN TESTING (PPD SKIN TESTING)

*****(If the PPD result is negative, administer PPD #2) *****

THE TWO-STEP PPD OR QUANTIFERON TB BLOOD TESTING METHOD IS REQUIRED FOR PRE-EMPLOYMENT

PPD step 1	1. DATE IMPLANTED:	1. DATE READ:	Results (mm induration)	[ ] Positive [ ] Negative
PPD step 2	2. DATE IMPLANTED:	2. DATE READ:	Results (mm induration)	[ ] Positive [ ] Negative
Quantiferon TB Blood Test		DATE:	RESULTS: [ ] Positive [ ] Negative	
Chest x-Ray (For + PPD only)		DATE:	RESULTS: [ ] Positive [ ] Negative	
TB SCREENING QUESTIONAIRE (Annually for + PPD only)			DATE:	

URINE DRUG SCREENING

***** (AttachaLaboratory Report) *****

A 8-PANEL DRUG SCREEN IS REQUIRED ANNUALLY

8 PANEL DRUG SCREENING	DATE:

SEASONAL INLUENZA VACCINE

*****(If exempt, provide proof)*****

A SEASONAL INFLUENZA VACCINATION REQUIRED ANNUALLY

INFLUENZA VACCINE	DATE:

IMMUNIZATIONS(REQUIRED FOR PRE-EMPLOYMENT ONLY)

*****(Please attach Laboratory Report)*****

MUMPS	DATE IMPLANTED	[ ] NON-IMMUNE [ ] IMMUNE	LAB VALUE:
MEASLES (RUBEOLA)	DATE IMPLANTED:	[ ] NON-IMMUNE [ ] IMMUNE	LAB VALUE:
RUBELLA	DATE IMPLANTED:	[ ] NON-IMMUNE [ ] IMMUNE	LAB VALUE:
VARICELLA	DATE IMPLANTED:	[ ] NON-IMMUNE [ ] IMMUNE	LAB VALUE:

[ ] This individual is free from a health impairment which is of potential or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances that may alter his/her behavior.

[ ]This individual is able to work with the following; imitations:

[ ]This individual is not physically/mentally able to work (specify)

Physician's Name/Signature: _____ Licence #:_____ Date: _____