VICTORIOUS HOME HEALTH CARE LIMITED
414 Dixie Highway Chicago Heights. Illinois, 60411

APPLICATION REQUIREMENTS

Please complete the application forms/provide the original copies of the below

- Resume
- State ID or Driver's license
- High school Diploma or GED
- Car insurance
- Current physical Examination result
- Current TB Test results
- First Aid
- CPR Card
- Current RN/LPN License
- CNA License
- W-4 State and Federal IRS
- Work Permit/Green card/US Passport
- Form I-94 (Immigration) and Delay filled Form I-9
- Emergency Contacts, Names and phone numbers
- Duly Filled Victorious Home Health Application Form

VICTORIOUS HOME HEALTHCARE LTD

411 Dixie Highway Chicago Heights IL, 60411. PH(815)464-9201 victorioushh@gmail.com.Fax (815) 464-9202

EMPLOYMENT APPLICATION:

An Equal Opportunity Employer: *We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital of veteran status, or any other legally protected status. In order to be considered an applicant, you must complete this form.*

General Information

Date of Application

Please select

Position Applying for: RN/NP | Home Care Aide | LPN | CNA

Full Name | Date Of Birth

E-Mail | Social Security Number

Address | Phone

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1. Do any of your friends or relatives work here? Yes No

   If yes, state full name and relationship.

2. Are you legally eligible for employment in this country? (Proof of citizenship or immigration status will be required upon employment) Yes No
3. Have you been convicted of a felony within the last 7 years? Yes No
4. Are you currently employed? Yes No
5. If you are currently employed, may we contact your employer? Yes No

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Work Preferences & Availability

1. Are you looking for a full-time or part-time position?
2. Are you available to work weekends?
3. Are you willing and able to service clients throughout the Cook County / Will County / Kankakee County (whether by driving or using public transportation)?

Education

Type of School	NAME OF SCHOOL	LOCATION (City, State)	NUMBER OF YEARS COMPLETED	MAJOR & DEGREE
High School				
College				
Bus. Or Trade School				
Professional School				

Have you ever been convicted of a crime? Yes No
If yes, explain number of conviction(s), nature of offense(s) leading to conviction(s), how recently such offense(s) was/were committed, sentence(s) imposed, and type(s) of rehabilitation (A conviction will not necessarily result in the denial of employment):

Have you ever worked under a different name? Yes No
If YES, what was it and what was the reason?

Do you have any relatives or friends that work for the Company? Yes No
If YES, what is their name?

In Case of Emergency, Please Contact:

Name ______ Relation ______

Phone Number ______

Previous Employment/Work History

Company: ______ Telephone Number: ______
Supervisor: ______ Date Started: ______
Job Title: ______ Date Ended: ______
Job Duties: ______ Reason for Leaving: ______ Address: ______

Company: ______ Telephone Number: ______
Supervisor: ______ Date Started: ______
Job Title: ______ Date Ended: ______
Job Duties: ______ Reason for Leaving: ______
Address: ______

Company: ______
Supervisor: ______ Telephone Number: ______
Job Title: ______ Date Started: ______
Job Duties: ______ Date Ended: ______
Address: ______ Reason for Leaving: ______

WHAT POSITION ARE YOU APPLYING FOR?

POSITION: ______

COMPANY NAME: ______

TITLE: ______

VICTORIOUS HOME HEALTH CARE

414 Dixie Highway, Chicago Heights, IL 60411

HOME HEALTH AIDES

JOB DESCRIPTION

The Home Health Aides ensures quality and safe delivery of home health care services. They assist in the provision of home health care services that reflect the home health care agency philosophy and standards of home health and nursing care of assigned clients.

DUTIES AND RESPONSIBILITIES

1. When home health aide services are offered, the services shall be under the supervision of a registered nurse in accordance with the plan of treatment. The home health aide is assigned to a particular patient by a registered nurse. Written instructions for patient care are prepared by a registered nurse or the appropriate therapist.

2. Duties of the home health aide may include:

   A) The performance of simple procedures as an extension of therapeutic services.

   B) Personal care, as defined in this Part.

   C) Ambulation and exercise of the patient.

   D) Household services are essential to health care at home.

   E) Assistance with medications that are ordinarily self-administered.

   F) Reporting changes in the patient's/client's condition and needs to the registered nurse or the appropriate therapist.

   G) Completion of appropriate records.

3) The registered nurse or appropriate therapist shall make a supervisory visit to the patient's residence at least every two weeks either when the home health aide is present to observe and assist, or when the home health aide is absent. The purpose of the advisory visits is to assess relationships and determine whether goals are being met.

JOB DESCRIPTION

Job Position: Home Service Worker

Reports to: Home Maker Service Supervisor

QUALIFICATIONS:

In order to be employed by the agency as a homemaker, an individual must:

a) Have a Social Security number and provide agency with documented verification of this number;

b) Must be 17 years of age or older. If a minor between 14 and 16 years of age who is not employed during school hours, has an employment certificate and meets all other requirements of the Child Labor Law [820 ILCS 205] and has an adult who is at least 21 years of age and who is legally responsible for the client who will supervise the worker; or be 16 years of age or older, enrolled in school and not employed during school hours.

c) Have provided to the agency, at least two written or verbal recommendations from present or former employers or, if never employed, references from at least two non-relatives;

d) Be able to communicate and be able to follow directions.

f) Have previous experience and/or training that is adequate and consistent with the specific tasks required for safe and adequate care of the customer;

h) Complete an EMPLOYMENT application with the agency

1) Shall provide services to the individual in accordance with his/her Service Plan.

2) Shall submit a bi-monthly calendar listing actual hours worked each pay period (1-15; 16-last working day of the month), as verified by the customer and in accordance with the number of hours authorized. The homemaker shall not claim more hours than approved unless prior approval has been granted by the supervisor

4) Shall maintain all customer information as confidential and not for release, either in writing or verbally, to anyone other than those designated by the client in writing;

5) Shall not subcontract to any other person, any of the services he/she has agreed to provide;

6) Shall provide services only while the individual is in his/her home.

i) complete an I-9 Immigration form, which must be retained by the agency;

j) Will authorize the agency to conduct a conviction background check from the Illinois State Police. This permission will require the prospective homemaker to sign the appropriate form provided by the agency.

A high school diploma or G.E.D or knowledge and skill equivalent to completion of four (4) years of high school is preferred. Experience in providing personal care to persons with disabilities either in own home or employment and knowledge of first aid and personal and environmental hygiene; knowledge of all areas of budgeting, housekeeping, nutrition, food preparation and clothing care are also preferred. A home maker that drives must be a licensed driver, able to provide proof of insurance and preferably have own transportation. Must have excellent expressive and comprehensive communication skills. Must successfully complete mandatory orientation and training(s). Must participate in ongoing training/ in-services.

Duties and responsibilities:

- Helping to establish household routines.
- Teaching proper clothing care.
- Performing routine housekeeping, such as making and changing of beds, dusting, washing dishes, vacuuming and keeping the kitchen and bathroom clean.
- Instructs customers in budgeting;
- Assists in preparation of shopping lists, encourages good buying practices, and makes the necessary purchases of food and other basic items where the customer cannot do the shopping; planning and preparing meals and special diets where necessary, attempting to conform to family dietary habits, and keeping in mind proper nutrition, and the family's food allowance encourages the family to correct inadequate or poor dietary practices
- Giving non-medical personal care as needed, assistance with dressing, washing and bathing, care of teeth or dentures, demonstrates and instructs family members in good hygienic practices; remind patient to take prescribed medications. Remind client to perform active range of motion if applicable.
- Accompany customer to doctor's office and other places as necessary to conduct personal business, may be required by the provider to use own car, to provide transportation as necessary.

- Preparing a written record of each case served consisting of daily records of activities, observations, progress toward goals and direct hours of service.

- Attend training classes and staff conferences.

Employment is conditional upon passing the Criminal Background Check. Initial performance evaluation will be conducted within 6 months of hire, thereafter annually.

This job description is subject to review or revision on an annual basis or when a change in job duties is required.

I have received a copy of the job description for my records. I have read the entire job description and understand my responsibilities. I understand that this constitutes an agreement between employer and myself, and does not guarantee employment.

____

Signature of Employee   Date

____

Signature of Supervisor   Date

State of Illinois
Illinois Department on Aging

ACKNOWLEDGEMENT OF LIMITATIONS ON MARKETING AND RECRUITING ACTIVITIES UNDER THE COMMUNITY CARE PROGRAM (HOMECARE AIDES) TRAINING

As a Homecare Aide under the Community Care Program (CCP), you represent the public face of your employer and the Illinois Department on Aging. It is your responsibility to provide approved in-home service in a professional and ethical manner to the older adults who receive services as participants in this program.

I ____, have viewed the Limitations on Marketing and Recruiting Activities Under the Community Care Program (Homecare Aides) and acknowledge my understanding of and responsibility to comply with the following non-exhaustive list of requirements under the CCP as set forth by federal and State laws, the 1915(c) Medicaid Waiver for the Elderly, regulations/rules, policies/procedures, the provider service certification, and the provider service agreement:

- An individual may choose at any time to not receive services for which eligibility has been determined under the CCP.
- An individual has the right to select a provider of his or her choice based on availability in the service area at any time during participation in the CCP.
- All information about an individual's case is to be kept confidential under the CCP. This information may be used ONLY for purposes directly related to the administration of this program. This information cannot and should not be shared between provider agencies.
  - Confidential case information includes, but is not limited to, the following items: Name, SSN, Date of Birth, Address, Medicaid Number and Status, Family/Guardian Name(s) and Contact Information, Phone Numbers, Financial Account Numbers, and Medication(s) or other health information.
  - This information may be maintained in any form or medium (i.e., electronic, oral, or paper).
  - Confidentiality continues beyond the termination of employment.
- The CCP prohibits the use of unsolicited telephone calls (cold-calling) and door-to-door solicitations; sales activities at community meetings, educational events and health care facilities; and cross-selling of non-CCP-related services to current and prospective program clients.
- Failure to comply with program requirements may subject you and/or your employer to sanctions imposed by the Department or other government officials with oversight responsibilities. Possible sanctions include, but are not limited to:
  - Participation in additional mandatory trainings.
  - Imposition of a ban on continued employment in the capacity as a caregiver under the CCP and other publicly funded programs in Illinois.
  - Placement of name on the Adult Protective Service Registry.

- **ORIGINAL OF THIS ACKNOWLEDGEMENT SHOULD BE MAINTAINED IN EACH EMPLOYEE'S PERSONNEL FILE.**

Agency Name:	
Signature:	Date:

Printed Name ______________________ Signature ______________________

SSN# ______________________ Date: ______________________

MARKETING AND PUBLIC RELATIONS

It is the policy of the Victorious Home Health Care Limited not to use or disclose identifiable health information for marketing or public relations purposes without the authorization of the individuals to whom the health information relates. It is further the policy of the agency to allow individuals to choose not to have their identifiable health information used for such purposes.

NOTIFICATION AND AUTHORIZATION

1. It is the policy of the agency that an individual's identifiable health information may typically only be used or disclosed pursuant to notification to and/or permissions granted by the individual, unless otherwise permitted or required by statute.

2. The agency will provide individuals with a copy of these policies and procedures prior to the commencement of employment or training, unless an emergency or a communications barrier makes providing or obtaining these policies and procedures impossible or impracticable, and will make a good faith effort to obtain acknowledgment of its receipt.

3. The agency allows individuals to request restrictions on the use and disclosure of their health information for treatment, payment, and healthcare operations. Following review by authorized agency personnel, the agency may choose not to agree to the requested restrictions. Victorious Home Health Care Limited will adhere, however, to any restrictions to which it agrees.

4. Acknowledgments of receipt of these policies and procedures will be retained by the agency for a minimum of six years. Any agreed upon restrictions arising out of a notification will remain in effect until revoked by the individual or until the individual is notified by the agency that Victorious Home Health Care Limited will no longer honor the agreed upon restrictions.

5. In the event the agency receives more than one authorization or permission from an individual that appear to be in conflict with each other, Victorious Home Health Care Limited will abide by the more restrictive client permission, until the conflict is resolved. Victorious Home Health Care Limited will attempt to determine the true intentions the affected individual and thus resolve the conflicting permissions as soon as is practicable.

6. An individual's health information may be used or disclosed by Victorious Home Health Care Limited for purposes other than treatment, payment, and health care operations, such as for research.

   Use and disclosure for such purposes requires a valid, signed authorization specifically detailing what information will be used or disclosed, how and by whom the information will be used or disclosed, and during what time period the information will be needed or a statement indicating there is no defined duration.

7. Authorizations are valid only for the conditions outlined in the document and may not be used for any purpose or purposes not specifically stated and agreed to by the signing individual. Victorious Home Health Care Limited will allow an individual to revoke his or her authorization at any time by submitting a written request. However, any such revocation shall not be retroactive to the extent that the agency has already relied and acted on a prior authorization.

BUSINESS ASSOCIATES

1. Victorious Home Health Care Limited discloses identifiable health information to other public or private entities with which the agency has contracted to provide services to the agency. Health information provided to such a business associate must be pursuant to an assurance that the business associate, and its sub-contractors, will use the information only for the purpose(s) intended, will restrict access to the information on a "need to know" basis only, and will otherwise take appropriate measures to safeguard the information in its possession. There must be a valid, signed business associate agreement in place before identifiable health information may be provided.

2. Except to the extent that client care might be compromised, the use or disclosure of health information by a business associate must comply with these policies and procedures. In addition, except to the extent that client care might be compromised, the use and disclosure of an individual's health information by a business associate must comply with any restrictions beyond the scope of these policies and procedures which are requested and subsequently agreed to by the agency.

3. Business associate agreements must be in writing and must contain agency-approved HIPAA compliant language and authorized signatures.

4. At any time, Victorious Home Health Care Limited determines that a business associate has violated a material term or obligation under the agreement relating to HIPAA compliance, the agency shall seek to immediately remedy the breach or, if that is not possible, to alter or terminate the agreement. Violations may also be reported by the agency to the Secretary of the Department of Health and Human Services.

5. It is the responsibility of each agency department, division, or operating unit contracting for services with third parties with whom identifiable health information will be shared to assure that valid business associate agreements are executed.

Employment Agreement

This Employment Agreement is between Victorious Home Health (Employer) and _______________ (Employee) Date of employment _______

Job Title: _______________

Employment status: ☐ Salaried ☐ Full time ☐ Part time ☐ Per diem

1. **EMPLOYMENT:** Employee shall provide to Employer services according to the signed job description.
2. **COMPLIANCE WITH EMPLOYER'S POLICIES AND PROCEDURES:** Employee agrees to submit to all of the policies and procedures of Employer.
3. **PROBATIONARY PERIOD:** Employee shall be subject to a 60-day probationary period during which Employer may terminate employment without prior notice. During this 60-day probationary period, employee shall not be eligible for unemployment benefits.
4. **COMPENSATION:** As compensation for the services provided by Employee under this agreement, Employer shall provide reimbursement in accordance with the attached signed wage agreement. Payday is every other Friday.
5. **CRIMINAL RECORD CHECK:** Employee authorizes Employer to contact the Illinois State Police for information regarding any criminal record. Should Employee be found to have any prior record of offenses, Employer reserves the right to immediately terminate employment.
6. **REFERENCE CHECK:** Employee authorizes employer to contact the references provided in the application for employment.
7. **CONFIDENTIALITY RELATED TO AGENCY BUSINESS OPERATIONS:** Employee recognizes that information regarding the Agency's business operations is strictly confidential and agrees to not divulge either directly or indirectly such information, without the prior written consent of the Employer. Such confidential information includes products, prices, future plans, business affairs, processes, trade secrets, customer lists, and any other information which is vital to the operations and assets of the Employer. Revealing confidential agency information shall be grounds for immediate termination.
8. **CONFLICT OF INTEREST:** Employee agrees to report any actual or potential situation that may result in personal, organizational, or professional gain to the employee, partner, or another organization.
9. **PATIENT CONFIDENTIALITY:** Employee agrees to keep strictly confidential all protected health information for all patients receiving services through the Agency as per the HIPAA training located in the Employee Handbook.
10. **RETURN OF RECORDS AND PROPERTY:** Upon termination of this Agreement, Employee shall return all property received by Employer (including the employee handbook, forms, notes, data, memorandum and equipment). Any unreturned property may be deducted from the Employee's final paycheck.
11. **TERMINATION:** Employees are required to give notice of termination two weeks in advance in order to ensure there is no disruption in patient care. Grounds for termination shall be at the discretion of the Employer.
12. **AMENDMENT:** This Agreement may be modified or amended if the amendment is made in writing and is signed by both parties.

By signing this agreement, I agree to all the above conditions. I verify that all information I have provided is true to the best of my knowledge and that I have no conflict of interest related to my employment with Victorious Home Health.

_______________ _______________

Employee Signature Date

____

Administrator/Director Signature

VICTORIOUS HOME HALTHCARE L T D

ACKNOWLEDMENT OF JOB DESCRIPTION

VICTORIOUS HOME HEALTH CARE does not discriminate on the basis of race, color, religion, national origin, sex, handicap or age.

☐ I have read this job description and fully understand the requirements set forth therein.

☐ I hereby accept the position of Home Healthcare provider and agree to perform the identified essential functions in a safe manner and in accordance with *VICTORIOUS HOME HEALTHCARE LTD* established procedures.

☐ I understand that as a result of my employment, I may be exposed to blood, body fluids, infectious diseases, air contaminants, and hazardous chemicals and that *VICTORIOUS HOME HEALTHCARE* will provide to me instruction on how to prevent and control such exposure.

☐ I further understand that I may also be exposed to the Hepatitis B virus and that *VICTORIOUS HOME HEALTHCARE LTD* will make available to me, free of charge, the Hepatitis B vaccination.

☐ I understand that my employment is at will, and thereby understand that my employment may be terminated at-will either by *VICTORIOUS HOME HEALTHCARE LTD.* or myself and that such determination can be made with or without notice.

Signature - Home Healthcare Provider Worker

Regarding Employment Application for ***VICTORIOUS HOME HEALTHCARE LTD***

I certify that the information contained in this application and in any resume provided by me or any party representing my interests is correct and complete to the best of my knowledge. I understand that any false statements, misinterpretations, or omissions made by me on this application or any supplement to it, will be sufficient grounds for rejection of this application or discharge after employment.

I grant VICTORIOUS HOME HEALTH CARE LTD the right to obtain pertinent information concerning me from former employers, educational institutions, and others, and I release all those providing or requesting such information from any liability that may arise by truthful disclosures or such investigations.

If I am hired, I understand that I am free to resign at any time, with or without cause and without prior notice, and the Company reserves the same right to terminate my employment at any time with or without cause and without prior notice, except as may be required by law. This application does not constitute an agreement or contract for employment for any specified period or definite duration. I understand that no representative of the Company, other than an authorized officer, has the authority to make any assurances to the contrary. I further understand that any such assurances must be in writing and signed by an authorized officer.

I understand it is the Company's policy not to refuse to hire a qualified individual with a disability because of that person's need for a reasonable accommodation as required by the Americans with Disabilities Act.

I also understand that if I am hired, I will be required to provide proof of identity and legal work authorization.

Your signature acknowledges you have read and agree to the above.

Applicant signature: ______________________________ Date______________________________

VICTORIOUS HOME HEALTHCARE L T D

PRE-SERVICE EXEMPTION

Employee Name

Reason New Employee Is Exempt from Pre-service Training:

☐ Has had previous documented and supervised training withing the past 2 years prior to this employment, equivalent to 24 hours of homecare aide pre-service training, as determined by the provider with appropriate documentation in the employee's personnel file; OR

☐ Has successfully completed RN, LPN, MD, physician assistant or CNA training in the past and has been employed in the field within the past 2 years, OR

☐ Has been employed as a CCP homecare aide withing the past year, verification by supervisor with signed statement in HR file; (complete verification form and attach)

This form completed by:

SUPERVISOR

EMPLOYEE SIGNATURE________________________

TRANSPORTATION

Many Healthcare provider positions require the healthcare provider to transport a client.

Do you have a dependable transportation

☐ Yes ☐ No

Make and moder car

License Plate #

Driver License #

Auto Insurance Policy #

Insurance Company

Insurance Agent Name

Insurance Agent Phone #

EMPLOYEE AUTOMOBILE RELEASE OF LAIBILITY

I ______________________________, understand that at my discretion I will be using my automobile as part of the duties in the care of patients assigned to me.

I acknowledge that I have the primary responsibility for my automobile insurance. I agree to hold *VICTORIOUS HOME HEALTHCARE LTD* harmless in the event that there is an accident in which there is damage to my automobile or injury to its occupants.

I hereby provide a copy of my car insurance card.

Employee Signature ____________________ Date ____________________

CONFIDENTIALITY OF CLIENT INFORMATION

Please read carefully as this is a legally binding document.

By accepting employment with *VICTORIOUS HOME HEALTHCARE LTD*, I agree to carefully refrain from discussing any client's condition or personal affairs with anyone outside the agency, unless expressly authorized to do so. I will not share any medical information with other clients or visitors without clear instruction provided to the agency. I acknowledge that all information seen or heard regarding clients, directly or indirectly, is completely confidential and is not to be discussed, even with my family and coworkers. My job as an employee requires that I govern myself by high ethical standards. Failure to recognize the importance of confidentiality is not only a breach of professional ethics but can also involve an employee in legal proceedings. I will not share any information about clients or the agency with the media. This is essential for the protection of both the client and Agency.

I have read and fully understand the above statement and agree to abide by these policies.

I understand that a breach of policy may result in disciplinary action and possible dismissal from employment.

____________________ ____________________

Applicant Signature Date

VICTORIOUS HOME HEALTHCARE LTD

414 Dixie Highway Chicago Heights IL, 60411. PH: 815-464-9201/Fax: 815-464-9202.
victorioushh@gmail.com

AUTHORIZATION TO PERFORM CRIMINAL BACKGROUND CHECK

I, ____, authorize *VICTORIOUS HOME HEALTHCARE LTD* to perform a criminal background check on me for purposes of employment only. I understand that I may request, in writing, a copy of the results of my criminal background check processed by *VICTORIOUS HOME HEALTHCARE LTD*.

______________________________ ______________

Signature Of Applicant Date

______________________________ ______________

WITNESS Date

A conviction on your criminal background history does not affect *VICTORIOUS HOME HEALTHCARE LTD* decision for employment provided you have supporting documentation to waive the conviction statement on your criminal record history.

VICTORIOUS HOME HEALTHCARE LTD
414 Dixie Highway Chicago Heights IL, 60411. PH: 815-464-9201/Fax: 815-464-9202.
victorioushh@gmail.com

SEXUAL HARASSMENT TRAINING ACKNOWLEDGEMENT FORM

I, ____, acknowledge that I have completed 1 hour of Sexual Harassment Training as required by the Illinois Human Rights Act while working at *VICTORIOUS HOME HEALTHCARE LTD* I understand that this training is mandatory for all employees, and I have completed the training in accordance with the Company's policies and procedures.

I acknowledge that sexual harassment in the workplace is prohibited by law and is not tolerated by *VICTORIOUS HOME HEALTHCARE*. I understand that I have a responsibility to maintain a workplace free from sexual harassment and to report any instances of sexual harassment to my supervisor or Human Resources department.

I understand that sexual harassment can take many forms, including but not limited to, unwanted sexual advances, requests for sexual favors, inappropriate physical contact, and verbal or physical conduct of a sexual nature. I understand that such behavior is unacceptable and may result in disciplinary action, up to and including termination of employment.

I understand that it is important to recognize the signs of sexual harassment and to know how to respond if it occurs. I have received training on how to recognize, prevent, and report sexual harassment in the workplace.

By signing below, I acknowledge that I have completed the sexual harassment training and that I understand my responsibilities as an employee of *VICTORIOUS HOME EALTHCARE LTD* in maintaining a workplace free from sexual harassment.

____ ____________________
Employee Signature Date

____ ____________________
Supervisor Signature Date

ELECTRONIC SIGNATURE AGREEMENT

This Electronic Signature Agreement ("Agreement") is made and entered into by and between *VICTORIOUS HOME HEALTHCARE LTD* ("Company"), and staff ______________________________ ("Signer"), for the purpose of electronic signature for documentation purposes.

Purpose
The purpose of this Agreement is to allow Signer to use electronic signature to sign Company's documents for documentation purposes.

Consent to Use Electronic Signature
By signing this Agreement, Signer consents to the use of electronic signatures for all Company's documents that require Signer's signature. Signer acknowledges that electronic signatures are legally binding and have the same effect as signatures in writing.

Method of Electronic Signature
Signer's electronic signature will be accomplished by using a secure and approved electronic signature system. Signer understands that electronic signatures are subject to authentication and security measures to prevent unauthorized use.

Responsibility for Security
Signer is responsible for maintaining the security and confidentiality of their electronic signature, including keeping passwords or other access codes confidential and not sharing them with others.

Signature Authentication
Signer's electronic signature is deemed to be valid and enforceable to the same extent as a handwritten signature once Signer has been authenticated through the electronic signature system.

Revocation of Signature
Signers have the right to revoke their electronic signature at any time by providing written notice to the Company. Such revocation will not affect the validity of any signed documents before the revocation.

Confirmation of Signature
Signer acknowledges and agrees that their electronic signature will constitute confirmation of the contents of the document signed, and will not dispute the validity or enforceability of the document based solely on the use of electronic signature.

Entire Agreement
This Agreement constitutes the entire understanding and agreement between the Company and Signer concerning the use of electronic signatures for documentation purposes.

Governing Law
This Agreement shall be governed by and construed in accordance with the laws of the state in which the Company operates.

Acceptance of Agreement

By electronically signing this Agreement, Signer acknowledges that they have read, understood, and agreed to be bound by all the terms and conditions contained in this Agreement.

Staff Name:____ Signature: ____________________________

Date: ____

State of Illinois
Illinois Department of Public Health

Health Care Worker Background Check

Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBI) to release information and photographs relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records and photographs relating to me, including but not limited to a local unit of government in any State, to release those records and photographs to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records and photographs, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or a health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25).

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name__________ Full Middle Name__________ Last Name__________

Mailing Address__________ City__________ State____ Zip Code______

Other Names Used__________ Telephone__________

States Where You Have Lived? __________

○ Male ○ Female Race____ Height 5' , 0" " Weight____ lbs Date of Birth________ Social Security Number ☐☐☐-☐☐-☐☐☐☐

(Enter a letter from below)

Hair Color________ Eye Color________ City/State of Birth__________

Race		
	A	Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
	B	Black or African American (Not Hispanic or Latino)
	H	Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
	I	American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
	U	Of undeterminable race. Of Untold mixture.
	W	Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft? ◯ Yes ◯ No
If "Yes," give full details and state.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ◯ Yes ◯ No If "Yes," give full details of each offense and the state in which convicted.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

(Signature) (Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

(Signature of Parent or Guardian when applicable) (Date)

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133

*** ALL FIELDS MUST BE COMPLETED OR APPLICATION WILL NOT BE PROCESSED***

PRINT

CLEAR FORM

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A — Documents that Establish Both Identity and Employment Authorization

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

OR

LIST B — Documents that Establish Identity

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

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

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

AND

LIST C — Documents that Establish Employment Authorization

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

   For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**.

   The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.

Acceptable Receipts

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

For receipt validity dates, see the M-274.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B, Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | **(b) Social security number**

Address

City or town, state, and ZIP code

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*.

(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)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

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

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

1. Expect to work only part of the year;

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

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

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

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

Specific Instructions

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

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

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

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

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . **1** $ ________

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . . **2** $ ________

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

VICTORIOUS HOME HEALTHCARE LTD

DIRECT DEPOSIT FORM

Employee Information:

Full Name:________________________________

Banking information:

Bank Name:_______________________________

Routing Number:___________________________

Account Number:__________________________

Account Type:________ Checking/_______ Savings (Select One)

I hereby authorize VICTORIOUS HOME HEALTHCARE LTD to initiate credit entries to my account indicated above and to credit the same such account. I acknowledge that the amount of credit may be adjusted as necessary to correct any errors in processing.

I certify that the above information is true and correct to the best of my knowledge. I understand that it is my responsibility to promptly notify VICTORIOUSHOME HEALTHCARE LTD of any changes to my banking information.

________________________________ ________________________

Employee Signature Date

________________________________ ________________________

HR Representative Signature Date

VICTORIOUS HOME HEALTHCARE LIMITED

HIRE RATE OF PAY FORM

Employee name: ____

Date: ____

Rate of Pay: ____

Employer/Human Resources Department: ____________________

CHANGES IN RATE OF PAY

Date: ____

Rate of pay: ____

Pay Period Is: ____

Pay day Is: ____

Signature of Employee ____

Signature of Employer ____

CHANGES IN RATE OF PAY

Date: ____

Rate of pay: ____

Signature of Employee: ____

Signature of Employer: ____