The below information MUST ACCOMPANY YOUR APPLICATION

CURRENT DRIVER'S LICENSE OR STATES ISSUED ID CARD________________

SOCIAL SECURITY CARD_____________

CURRENT CPR___________

CURRENT FIRST AID_______________

TB TEST (WITHIN 24 MONTHS)_______________

Employment Application

Date: ____________

Full Name: ______________________________ D.O.B.____________ SSN: ____________

Current Address: ______________________________ City: ________________ State: ________

Zip Code: __________ County: ________________ Cell Phone: ________________

Position Applied for: ________________Salary Desired: $________ C.N.A _____ PCA ___ LPN __ RN _ Med Tech ___

☐ Full Time ☐ Part Time When are you available to begin work? ____________

Type of School	Name Of School	Years Completed	Diploma/ Degree
High School			
College or Trade			
Professional			
Other			

Do you drive? ☐ Yes ☐ No Do you have a car? ☐ Yes ☐ No

First Aid: ☐ Yes ☐ No CPR: ☐ Yes ☐ No Current TB Test: ☐ Yes ☐ No

Employment History:

Name Of Company	Company Address	Job Title:	Salary:	Phone Number	Supervisor	Can we contact this employer as a reference? If not, please explain why

References:

Name Of Reference	Phone Number	Relationship

I certify that all statements in this application and any attached documents are true, complete and accurate. I understand that false information may result in rejection or termination of my employment.

Signature: ______________________________ **Date:** ______________

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

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

Address

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

Multiply the number of other dependents by $500 . . . . ▶ $ ______

Add the amounts above and enter the total here . . . . **3** $

Step 4 (optional): Other Adjustments

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

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . **4(b)** $

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

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

COMMUNITY HEALTH CARE, INC.

Title: Home Health Provider

Purpose: Home Health Provider is responsible for rendering safe and adequate services to individuals in their private home environment. Supportive services of home management, personnel care and respite/custodial supervision will enable individuals to remain in their homes without premature institutionalization.

Hours: 35 Hours per week

QUALIFICATIONS:

- High School Diploma
- CPR Certification
- Current Criminal Record Report

KNOWLEDGE, SKILLS AND ABILITIES

- Must have understanding of disabled, aged and frail individuals requiring services
- Must understand the needs of caregivers
- Must be able to communicate well
- Must be able to deliver the level of home management and personal care required
- for assigned clients
- Must be able to demonstrate competency in correctly performing tasks as required through recommended training

LINE OF AUTHORITY:

Home Health Provider is guided by the Home Health Supervisor.

DUTIES:

- Provide home management services which are essential to client's care
- Assist with personal care such as, bathing, care of mouth, skin and hair
- Assist with ambulation
- Provide respite/custodial care
- Assist with self-administration of medications which are ordered by a physician or
- other authorized person by state law to prescribe
- Record and report changes in client's condition, family situation or needs to the appropriate professional
- Complete appropriate reports of hours worked and tasks performed
- Participate in ongoing staff in-service training and development

OVERTIME STATUS:

Non-exempt   Salary: $7.25-13.50 per hour

Signature:________________________________ Date :____________

FAIR CREDIT REPORTING ACT DISCLOSURE STATEMENT

By this document, Community Health Care discloses to you that a consumer report, including an investigative consumer report containing information as to your character, general reputation, personal characteristics and mode of living, may be obtained for employment purposes as part of the pre-employment background investigation and at any time during your employment. Should an investigative consumer report be requested, you will have the right to request a complete and accurate disclosure of the nature and scope of the investigation requested and a written summary of your rights under the Fair Credit Reporting Act. Please sign below to acknowledge the receipt of this disclosure.

Applicant's/Employee's Signature ______________________________

Date ____________________

AUTHORITY FOR RELEASE OF INFORMATION

I authorize BackgroundChecks.com to release criminal history and consumer report in connection with my application for employment with Community Health Care.

(Please print clearly)

Last Name	First	Middle	Maiden
______________	______________	______________	______________
Social Security Number	Date of Birth	Sex	Race
______________	______________	______________	______________

Applicant's/Employee's Signature ______________________________

Date ____________________

Declination Form

The Federal Occupational Safety and Health Administration (OSHA) which address occupational exposure to bloodborne pathogens requires that vaccinations for Hepatitis B be made available to all employees who have occupational exposure to bloodborne pathogens. Community Health Care, Inc., will incur all cost for employees/volunteers to receive the Hepatitis B Vaccination. Prior approval is needed by Agency Director before an employee take the vaccination.

I have been informed of OSHA requirements and understand the need/purpose of the vaccination but I decline to take the Hepatitis B Vaccination.

Signature ____________________ Date: ____________________

Employee Statement of Acknowledgement

This is to acknowledge that I have received a copy of Community Health Care, Inc.'s personnel policies and procedures. I understand that it provides guidelines and summary information about Community Heath Care, Inc. personnel policies, procedures, benefits, rules of conduct. I also understand that it is my responsibility to read. understand, become familiar with, and comply with the standards that have been established. I further understand that Community Health Care, Inc. reserves the right to modify, supplement, rescind, or revise any provision, benefit, or policy from time to time, with or without notice, as it deems necessary or appropriate.

Signature ____________________________________ Date ____________________

Transportation Waiver

I consent and agree transporting of clients and family caregivers during work hours and for completing required tasks activities will be my sole responsibility for assuring that proper liability insurance is kept current on all of the vehicles use for this purpose. Further, I accept full risk of liability for any expense. damage. loss of property or injury that may occur while transporting clients and family caregivers during approved work hours and that the agency, Community Health Care, Inc., will not be liable for such aforementioned conditions involving accident liabilities.

Signature ____________________ Date ____________________

Medication Administration

I understand that I am not to administer medication unless I have a current medication technician's license issued by Maryland Board of Nursing . I also understand that I am not to administer medication unless the agency's RN has delegated the task on the Plan of Care .

Signature ____________________________________ Date ____________________

WAIVER OF LIABILITY FOR WORK PERFORMED AFTER CLIENT SCHEDULED HOURS AND VOLUNTEERSERVTCES

I understand any work activities or visits performed by me after completing authorized hours according to my Work Schedule for clients receiving official home care/health services through Community Health Care is my sole responsibility regarding any type of risk of liability that may be incurred after approved hours. Therefore, I agree that any expense, damage, accident or loss is not the liability of Community Health Care

I further agree that if I am assisting clients through Community Health Care in a Volunteer capacity, the agency also is released from any expense, damage, accident or loss that may be incurred at any time with work, activities or visits.

Employee Signature: ____________________
Date: ____________________

NOTICE OF NO SMOKING IN CLIENTS' HOMES

According the Division of Health. Service Regulations, a bill was issued in effect October 1, 2007 which prohibits the smoking by employees in homes of their clients. As employees of Community Health Care, you are, hereby, notified of this bill and required to follow this "No Smoking in Clients' Homes" notice. Violators will be subject to disciplinary action.

Employee Signature: ____________________
Date: ____________________

NOTICE OF NON-PAYMENT OF SERVICE HOURS PROVIDED TO CLIENT WHEN DENIAL OF CLAIM BY MEDICAID

I am hereby notified of non-payment of service hours provided by me to clients who are denied claim reimbursement from Medicaid to the agency due to hospitalization, ineligible for services due to Medicaid expiration, inpatient skilled nursing facility service, adult care home or any other conditions described by Medicaid to be non-reimbursable for Personal Care Services.

Employee Signature: ____________________
Date: ____________________

Use of Confidential Information by Employee

I as an Employee of Community Health Care do hereby acknowledge that I must comply with a number of State and Federal Laws which regulate the handling of confidential and personal information regarding both customers/clients of thiscompany and its other employees. These laws may include but not be limited to FACTA, ThePrivacy Act, GrammlLeachIBliley, and ID Theft Laws (where applicable). I understand that I must maintain the confidentiality of ALL documents, credit card information, and personal information of any type and that such information may be used only for the intended business purpose. Any other use of said information is strictly prohibited. Additionally, should I misuse or breach, any personal information of said clients and/or employee; I understand I will be held fully accountable both civilly and criminally, which may include, but not limited to Federal and State fines, criminal terms, real or implied financial damages incurred by the client, employee, or this company.

Employee Signature: ____________________
Date: ____________________

Employee Non Compete Clause

I, ______________________________, understand when a client recruited by Community Health Care is assigned to me and I later terminate the assignment from the Agency, I cannot be placed with the client for 90 days under another working relationship. If another working relationship outside of Community Health Care is formed, a Finder's Fee of $500 will be charged by deducting money owed from my pay.

______________________________ ______________________

Employee Name Date

Required Employee Certifications

It is required that First Aid ($35), CPR ($35), current TB Test ($40) and Department of Public Safety Fingerprint Background Check ($45) be submitted to the office of Community Health Care within 30 days of hiring. You will be charged for each document not turned in after 30 days by payroll deduction.

______________________________ ______________________

Employee Name Date

PROPERTY DAMAGES AND BODILY INJURIES RESPONSIBILITY

I, ______________________________ consent and agree that property
print name
damages to the structure of the client's dwelling inside and outside which includes such things, and is not limited, to frame, windows, furniture, lawn, trees and shrubberies are my responsibilities. I further accept full responsibility and liability for any expenses, damages, losses of personal properties of client, family, friends and whosoever is present inside or outside the home for which I am involved during approved work hours. It is, also my responsibility to be accountable for any bodily injuries that may occur on my behalf to client, family friends and whosoever is present inside and outside the home during approved work hours.

Community Health Care, Inc. will not be liable for such aforementioned conditions involving negligence or accidents that are not covered under the company's General Liability Insurance client

______________________________ Date ____________

Signature

REQUIRED DRUG TESTING

To ensure the well being of our clients and the proper use of techniques by our employees, we are enforcing safety within the work environment. Therefore, in case of an injury or any type of accident involving you and/or the client, you are required to submit a drug test within 24 hours of the occurrence from a reputable facility such as a hospital, doctor's office, Urgent Care and Laboratory Centers.

My signature below indicates that I have been made aware of this required personnel procedure.

Employee Signature ______________________

Date: ______________________

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. 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. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
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		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		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		

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Community Health Care, Inc.

Communityhealthcareinc.com

Missing Time Acknowledgement

Dear Employee's,

Effective June 1, 2016 Reduced the 6 unexcused missing times to 4 unexcused missing times per month. DHMH help desk team is reviewing missing times very closely. Repeatedly unexcused missing time will not be authorized by DHMH. The agency is reimbursed by Medicaid which is paid through DHMH. Medicaid is a federal funded program. DHMH implemented ISAS to monitor home health provider's time while in the home with the Medicaid participants. DHMH WILL NOT PAY THE PROVIDER'S TIME IS NOT PROPERTY DOCUMENTED. If you miss punching in your shift these are the steps you need to follow to request payment for hours worked.

1. Call the office (301)-341-2273, Email: Communityhealthcaremd@verizon, or Text (202)-400-1483

2. Have the following information: Clients name, your name, date & time you missed punch with the reason why you were unable to successfully clock in or out.

3. Keep your own records o documentation

4. YOU ARE ALLOWED 4 MISSING TIMES PER MONTH

5. The deadline to submit all missing time in the month is the end of the month. Example) I cannot submit time for May in July. The agency's deadline for missing time is the 2nd of the following month. Ex) time in July must be reported by July 30th so I can submit missing time by the 2nd.

6. You may call on the 10th of every month to see if the hours were approved for the previous month. OFFICE STAFF WILL NOT CALL YOU. YOU MUST HAVE YOUR DATES, CLIENT'S NAME, AND THE AMOUNT OF HOURS THAT'S OWED. IT IS IMPOSSIBLE FOR THE OFFICE STAFF TO KEEP UP WITH YOUR MISSING TIME. THIS IS YOUR RESPONSIBILITY

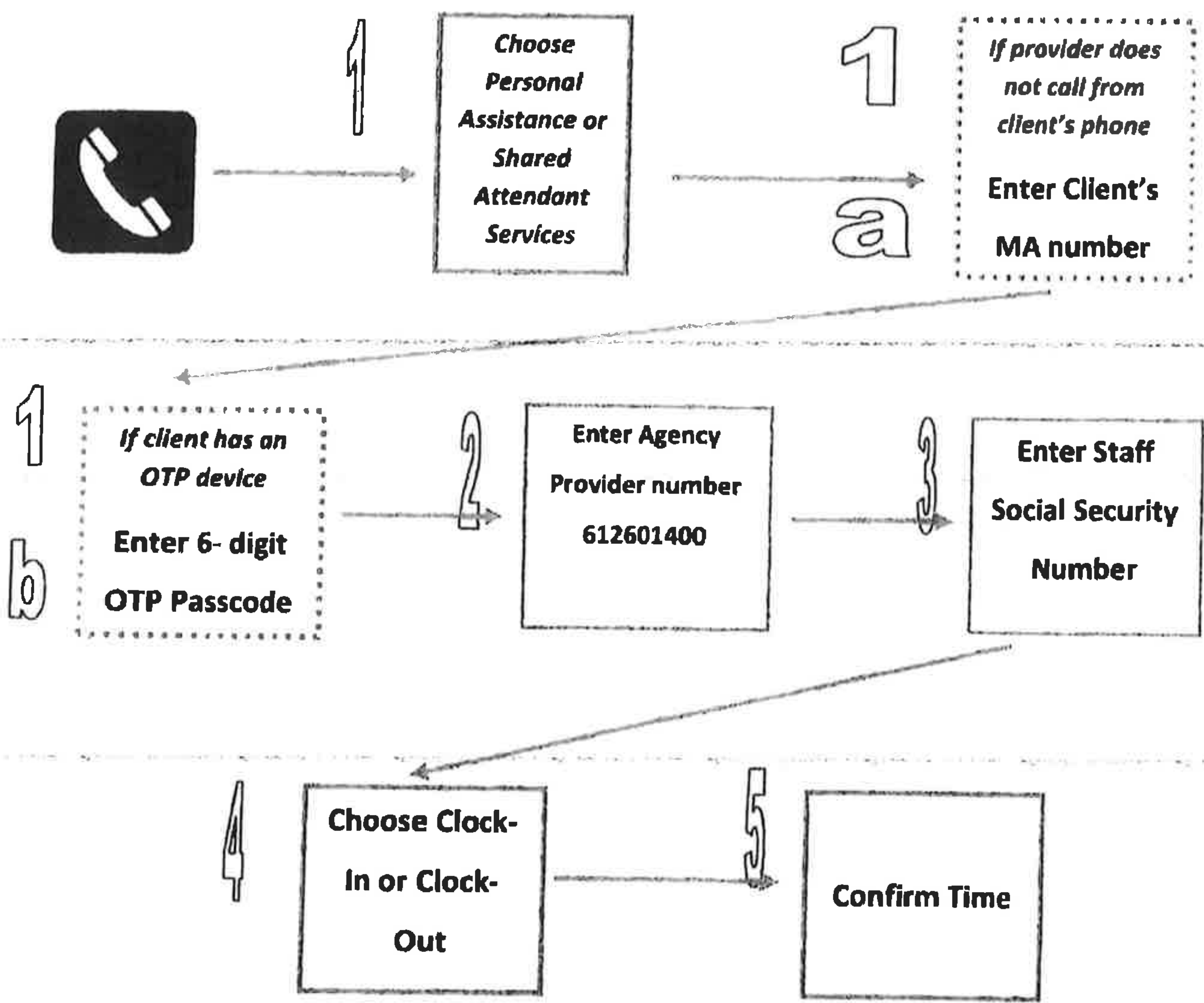
7. Please call about your missing time within the 30 days. Example) it is July and employee calls about missing time for March. This will take longer to be paid. Office staff has to reach and consult with payroll. Please make sure you follow up about your unpaid days in a timely manner.

We do not like for our employee's to have payroll issues. We want you to be paid for all the hours worked. However, it is important to follow the regulations and polices in order to be paid. As a courtesy Community Health Care will send you a letter with your missing time every payroll period. PLEASE keep record of your missing times!

Providers who have more than one client may not be clocked in for 2 clients at the same time. That is considered doubled billing. This is violating COMAR regulations. If you are clocked in for 2 clients at the same time you will not be paid for both shifts. In addition to not being paid you will be written up. This is considered fraud. This will not be tolerated by the agency.

I fully understand the policies and procedures of requesting pay for missing time.

Employee Signature: ______________________________ Date: ____________



By signing this form, you confirm that you completely understand the procedures for clocking in/out. If you have any questions or concerns please contact the office at 301-341-2273

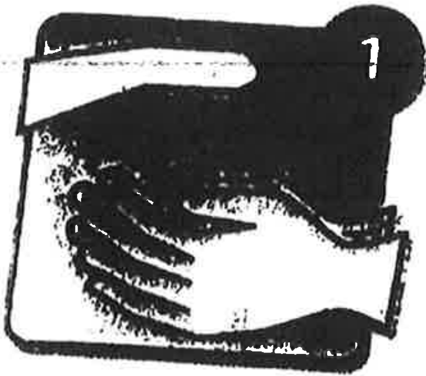
____

Employee's Signature

By signing this form, you confirm that you have completed and understand the procedures for washing your hands. If you have any questions or concerns please contact the office at 301-341-2275

____
Employee Signature

Hand Wash Step



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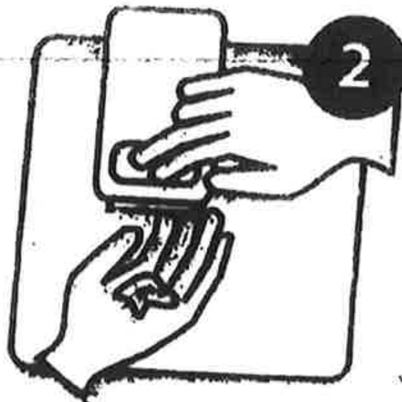

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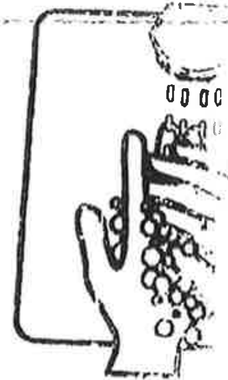
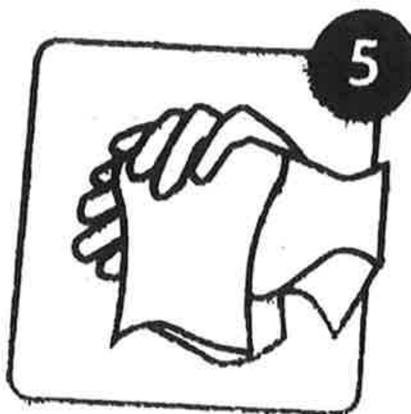


Rinse



Dry