The below information MUST ACCOMPANY YOUR NC *CNA* APPLICATION

CURRENT DRIVER'S LICENSE OR STATE ISSUED ID CARD _____

LIABILITY INSURANCE FOR AUTOMOBILE WHEN TRANSPORTING CLIENTS (NC ONLY)

NAME OF INSURANCE COMPANY_____

COPY OF INSURANCE CARD_____

SOCIAL SECURITY CARD _____

CERTIFIED NURSING ASSISTANT _____

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:** _____

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 _____

AUTHORITY FOR RELEASE OF INFORMATION
State Access Only
Name Check Access

I authorize the North Carolina Department of Public Safety through the State Bureau of Investigation to perform a North Carolina name-based criminal history record information check in connection with my application for employment, my employment or volunteer services with COMMUNITY HEALTH CARE INC pursuant to DHHS-LONG TERM - STATE AND FED - NCGS 122C-80B/131D-40A A1/131D-40A A1.

(Type or print clearly)

Last Name	First	Middle	Maiden
_____	_____	_____	_____
Social Security Number (Optional*)	**Date of Birth**	**Sex**	**Race**
_____	_____	_____	_____

I understand that the North Carolina State Bureau of Investigation, officials and employees shall not be held legally accountable in any way for providing this information to the above named agency, and I hereby release said agency and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that the above named agency cannot provide a HARD COPY of the results of this criminal history record check to me.

*Disclosure of social security number is entirely voluntary and not required. If disclosed, the social security number will be utilized to assist with accurate identification/exclusion of possible criminal history records.

Applicant's/Employee's/Volunteer's Signature

_____

Date

_____

This form must be maintained on file with the above named agency for one year. UPON COMPLETION OF THIS FORM, MAIL A PHOTOCOPY TO THE ADDRESS INDICATED BELOW:

State Bureau of Investigation
Criminal Information and Identification Section
Attn: Applicant Unit
Post Office Box 29500
Raleigh, North Carolina 27626-0500

ORI # HCPCA1887 - COMMUNITY HEALTH CARE INC

HCPCA1887

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

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

Step 3: Claim Dependents

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

▶ _____ ▶ _____

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

Employers Only

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

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:_____

OSHA Declination Form

The Federal Occupational Safety and Health Administration (OSHA) which addresses occupational exposure to bloodborne pathogens requires that vaccinations for Hepatitis B be made available to all employees or volunteers to receive the Hepatitis B vaccination. Community Health Care, Inc. will incur all costs for employees or volunteers to receive the Hepatitis B vaccination. Prior approval is needed by the Agency director before an employee takes the vaccination.

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

Employee Signature: _____

Date: _____

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 Health Care, Inc.'s personnel policies, procedures, benefits and 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 position, benefit, or policy from time to time, with or without notice, as it deems necessary or appropriate.

Employee Signature: _____
Date: _____

Transportation Liability Waiver

I consent and agree transporting of clients and family caregivers during work hours and for completing required task activities will be my sole responsibility for assuring that proper liability insurance is kept current on all the vehicles used 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.

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 $500.00 will be charged by deducting money owed from my pay.

Employee Signature: _____
Date: _____

WAIVER OF LIABILITY FOR WORK PERFORMED AFTER CLIENT SCHEDULED HOURS AND VOLUNTEER SERVICES

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 to 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 Client's 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 this company and its other employees. These laws may include, but not be limited to- FACTA, The Privacy Act, Gramm-Leach-Bliley, 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: _____

Property Damages and Bodily Injuries Responsibility

I _____ consent and agree that property 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 whosever 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 whoever 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.

Employee Signature: _____
Date: _____

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, doctors office, Urgent Care, and Laboratory Centers.

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

Employee Signature: _____
Date: _____

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

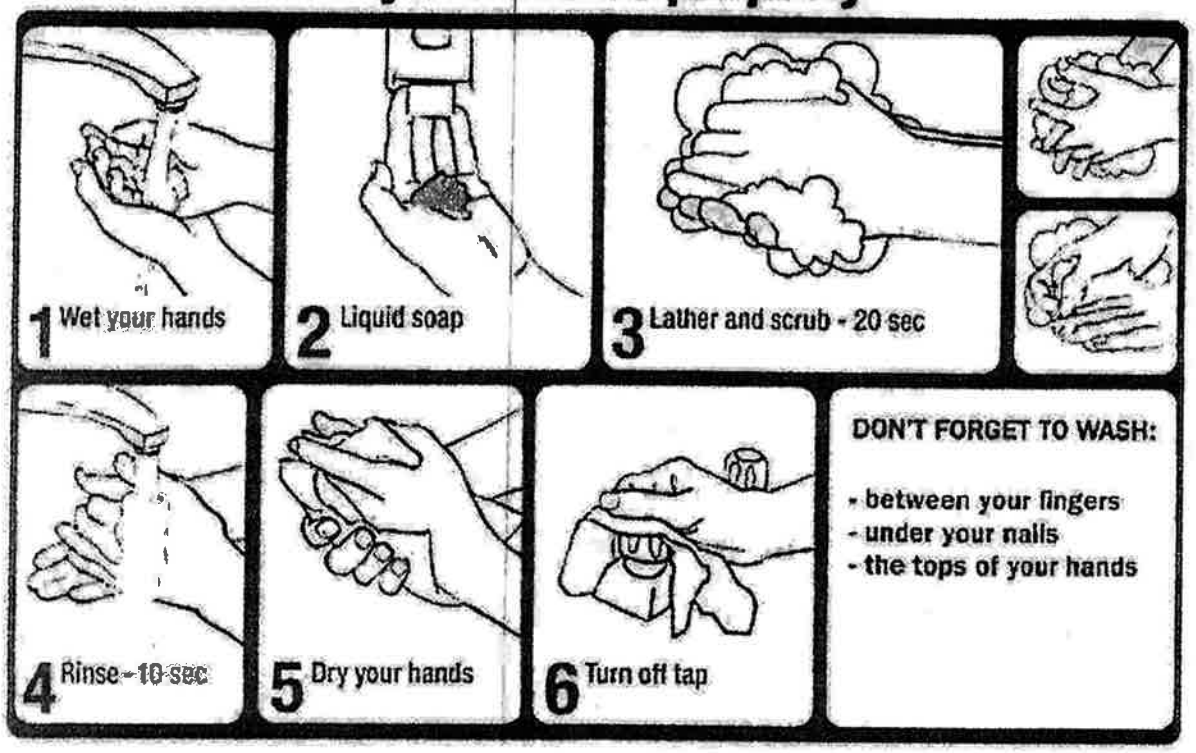
Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	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. 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
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		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.

How to wash your hands properly



By signing this form, you confirm that you have completed and understand the procedures for washing your hands. If you have questions or concerns, please contact the office at 301-341-2273 (Maryland location) or 335-285-7001 (North Carolina location).

_____

Employee Signature

Community Health Care, Inc.
Communityhealthcareinc.com

MEMORANDUM OF UNDERSTANDING

Date: November 5, 2020

To: Clients and Employees

From: Leah Martin, Director

Regarding: COVID-19 Service Requirements

In lieu of the increasing positive COVID-19 cases according to information shared by Center of Disease Control (CDC), all clients and employees are strongly advised to take the yearly influenza (flu) shot and follow the specified guidelines as mentioned. Please note these guidelines are highly recommended by Center of Disease Control (CDC) to guard and prevent the spreading of COVID-19.

- Wear a cloth face covering.
- Practice social distancing.
- Wash your hands often with soap and water for at least 20 seconds. This is especially important after using the bathroom, before eating and after blowing your nose, coughing or sneezing.
- Avoid close contact with people who are sick and avoid touching your eyes, nose and mouth until you wash your hands.
- Stay home when you're sick and cover your cough or sneeze with a tissue, then toss tissue in the trash.
- Clean frequently touched objects and surfaces with a common household cleaning spray or wipe.
- Use an alcohol-based hand sanitizer with at least 60% alcohol when washing your hands if possible.

This signed acknowledgement of your understanding of the increased risk that COVID-19 can be transmitted in any place of public accommodation. This documentation will remain a part of your employee and or client records as long as you are affiliated with our agency. Continue to be vigilant and keep a healthy immune system.

I acknowledge and understand that there is an increased risk that COVID-19 can be transmitted in any place of public accommodation including but not limited to offices, transportation vehicles and residences. By entering our premises, transportation vehicles, and providing and receiving services, I agree to assume the risk of exposure to the COVID-19 virus and release Community Healthcare from compensation of all liability.

_____ _____

Name (Printed) Signature

_____ _____

Date Business Relationship (Client or Employee)

Community Healthcare, Inc.
1400 Mercantile Lane, Suite 244
Largo, Maryland 20774
Email: communityhealthcaremd@verizon.net
Office: 301-341-2773
Fax: 301-341-2274