

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/Home Phone: _____
 Salary Desired: \$ _____ Position Applied: _____ 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	YEAR 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 #	SUPERVISOR	MAY WE CONTACT? IF NO, 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 _____

Privacy Act Statement

This privacy act statement is located on the back of the FD-258 fingerprint card.

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

As of 03/30/2018

See Page 2 for Spanish translation.

NONCRIMINAL JUSTICE APPLICANT'S PRIVACY RIGHTS

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below. All notices must be provided to you in writing.¹ These obligations are pursuant to the Privacy Act of 1974, Title 5, United States Code (U.S.C.) Section 552a, and Title 28 Code of Federal Regulations (CFR), 50.12, among other authorities.

- You must be provided an adequate written FBI Privacy Act Statement (dated 2013 or later) when you submit your fingerprints and associated personal information. This Privacy Act Statement must explain the authority for collecting your fingerprints and associated information and whether your fingerprints and associated information will be searched, shared, or retained.²
- You must be advised in writing of the procedures for obtaining a change, correction, or update of your FBI criminal history record as set forth at 28 CFR 16.34.
- You must be provided the opportunity to complete or challenge the accuracy of the information in your FBI criminal history record (if you have such a record).
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the FBI criminal history record.
- If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at <https://www.fbi.gov/services/cjis/identity-history-summary-checks> and <https://www.edo.cjis.gov>.
- If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI by submitting a request via <https://www.edo.cjis.gov>. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)
- You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.³

¹ Written notification includes electronic notification, but excludes oral notification.

² <https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement>

³ See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 34 U.S.C. § 40316 (formerly cited as 42 U.S.C. § 14616), Article IV(c); 28 CFR 20.21(c), 20.33(d) and 906.2(d).

Employee's Withholding Certificate

Department of the Treasury
Internal Revenue Service

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.

2025

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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.)		

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (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)
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General Instructions

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 and you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 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 2025 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 17, 2026.

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

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

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

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

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

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

Specific Instructions

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

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

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

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount 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 2025 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 2025 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: { \$30,000 if you're married filing jointly or a qualifying surviving spouse; \$22,500 if you're head of household; \$15,000 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	\$700	\$850	\$910	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
\$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
\$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
\$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
\$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
\$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
\$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
\$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
\$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
\$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
\$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
\$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
\$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
\$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	\$200	\$850	\$1,020	\$1,020	\$1,020	\$1,370	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040
\$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
\$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
\$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
\$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
\$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
\$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
\$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
\$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
\$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
\$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
\$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
\$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
\$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	\$450	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870	\$1,870	\$1,870	\$1,890
\$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
\$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
\$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
\$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
\$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
\$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
\$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
\$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
\$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
\$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
\$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
\$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
\$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

COMMUNITY HEALTH CARE, INC.

TITLE: Home Health Provider/Nurse Aide

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

HOURS: Approved Weekly Client Hours

QUALIFICATION: + High School Diploma or GED
+ Certified Nurse Aide/Personal Care Aide

- CPR Certification
- First Aid Certification
- Current TB Test
- Current Criminal Record Report

KNOWLEDGE, SKILLS AND ABILITIES

- Must have understanding of disabled, aged and frail individuals requiring services
- Must understand the needs of caregiving
- Must be able to communicate well
- Must be able to deliver and 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/Nurse Aide is guided by Home Health Supervisor

DUTIES: + Provide home management services which are essential to client's caregiving

- Assist with personal care such as bathing, oral care, skin care, grooming, dressing, toileting, meal preparation, ambulating, transferring and light housekeeping
- Assist with self-administration of medications which are ordered by a physician or other authorized person by state law to prescribe medications
- Record and report changes in client's condition, family situations or needs to the appropriate professionals
- Complete appropriate reports of approved hours worked and tasks performed
- Participate in ongoing staff in-service training and development

EMPLOYMENT STATUS: Non-exempt

Salary: open

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 Personnel Policies and Procedures Acknowledgement

This is to acknowledge that I have received and read a copy of Community Health Care, Inc.'s Personnel Policies and Procedures which has been made available to me on its website. I understand that it provides guidelines and summary information about Community Health Care's personnel policies, procedures, benefits and rules of conduct. I also understand that it is my responsibility to 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 _____

Acceptance and Review of Personnel Policies

I have read, understood and accepted the Personnel Policies of Community Health Care, Inc. I received my copy of the Personnel Policies through access to Community Health Care website.

Signature _____ Date _____

Transportation Waiver

I consent and agree transporting clients, family members and others during work hours will be my sole responsibility for assuring that proper liability insurance is kept current on all vehicles used by me for this purpose. Furthermore, I accept full risk of liability for any and all expenses, damages, losses of property and/or injuries that may occur while transporting clients, family members and others 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 Maarland Board of Nursing or North Carolina Division of Health Service Regulation (DHSR). 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'S APPROVED WORK SCHEDULE

I understand any unapproved work hours over Client's Approved Work Schedule are considered not working according to the authorized hours by Maryland Department of Health and Mental Hygiene (DHMH), North Carolina Department of Medicaid and Community Health Care, Inc. Therefore, I understand that no pay will be rendered by DHMH, NC Department of Medicaid and Community Health Care, Inc.

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, Inc. 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.

Signature _____ Date _____

NOTICE OF NON-PAYMENT OF WORK HOURS PROVIDED TO CLIENTS WHEN DENIED CLAIMS BY DHMH AND NC DEPARTMENT OF MEDICAID

I am hereby notified of non-payment of clock ins and clock outs when hours are reported for clients who are denied claim reimbursements for missing time, improper clock in or clock out, hospitalization, ineligibility for services due to Medicaid expiration, inpatient skilled nursing facilities, mental institutions, rehabilitation centers and any other conditions described by DHMH and NC Department of Medicaid.

Signature _____ Date _____

Use of Confidential Information by Employee

I as an employee of Community Health Care, Inc. 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 clients of this company and its other employees. These laws may include but not limited to FACTA, The Privacy 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 employees, 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.

Signature _____ Daate _____

EMPLOYEE NON COMPLETE CLAUSE

I understand when a client recruited by Community Health Care is assigned to me and I later terminate the assignment from Community Health Care, Inc., 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.

Signature _____ Date _____

REQUIRED EMPLOYEE CERTIFICATION DEDUCTIONS

It is a requirement that First Aid (\$35), CPR (\$35) current TB Test (\$40) and Department of Public Safety Fingerprint Background Check (\$45 - \$65) be submitted to the office of Community Health Care, Inc. within 30 days of hiring. For each certificate processed through Community Health Care, Inc., the cost will be deducted from your pay check.

Signature _____ Date _____

PROPERTY DAMAGES AND BODILY INJURIES RESPONSIBILITY

I consent and agree that property damages to the structure of a 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.

Signature _____ Date _____

REQUIRED DRUG TESTING

To ensure the well being of our clients and the proper use of techniques by our employees, we enforce safety within the work environment. Therefore, in case of an injury and/or any type of accident involving the employee and/or the client, the employee is 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.

Signature _____ Date _____

COMMUNITY HEALTH CARE, INC.

PERSONNEL POLICIES AND PROCEDURES

DATE: January 10, 2025

Page 18

XXVIII. OVERTIME UPDATED POLICY

This policy defines clear procedures about overtime restrictions for work hours of full time office employees, nurse aides and part time aides. **Office employees** who work 35 hours up to 40 hours a week must always adhere to their approved work schedules. No overtime hours will be paid without a written advance request made with a signature from the employee and signatures from your supervisor and Director indicating approval.

For all **full time nurse aides** no pay will be given for any overtime hours that are outside of the Clients Approved Work Schedules according to Maryland Department of Health and Mental Hygiene (DHMH) and North Carolina Department of Medicaid. An example is if the client is approved for 35 hours and you work 36 or 37 hours over the approved schedule, you will not be paid. The same applies for employees that have clients who receive 40 hours a week. If any full time nurse aide has a client over 40 hours a week, you must have advance approval before working that Client Schedule. **WE DO NOT PAY OVERTIME FOR WORK DONE OVER 40 HOURS A WEEK WITHOUT ADVANCE WRITTEN APPROVAL.**

All **part time nurse aides**, also must strictly follow the Clients Approved Schedules. Example is, if the client is approved for 20 hours a week, you cannot work over 20 hours a week. Any hours over the scheduled 20 hours are considered not working. DHMH and North Carolina Department of Medicaid do not pay for hours over the client approved work week schedule. Community Health Care does not pay either.

Remember to work your approved schedules. No tolerance or payment is given for overtime when the above procedure is not followed.

Employee Signature: _____

Date: _____

COMMUNITY HEALTH CARE, INC.

PERSONNEL POLICIES AND PROCEDURES

DATE: January 10, 2025

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XXIX. CLIENT APPROVED WORK SCHEDULE POLICY

All clients will have approved work schedules for their nurse aides for the number of weekly hours approved by Maryland Department of Health and Mental Hygiene (DHMH) and North Carolina Department of Medicaid. The standard work week is Sunday through Saturday. Appropriate Client Schedules will be reviewed and approved by Supervisor and Director. At no time should a nurse aide clock in and clock out over 12 hours consecutive for a given shift. Example: If you clock in at 8:00 a.m. until 9:00 p.m., a total of 13 hours or more are not permissible. You would only be paid for 12 hours and not the one (1) additional hour.

It is highly mandatory that all employees and clients follow the approved Client Schedule. DHMH and North Carolina Department of Medicaid along with Community Health Care DO NOT PAY for unapproved client hours. Employees must never work over approved weekly hours for their clients because those hours are unauthorized by DHMH, North Carolina Medicaid and Community Health Care. Employees must only report hours worked according to Client Approved Work Schedules for the week.

All clients and employees are informed that no pay will be given to employees when clients are in hospitals, nursing facilities, mental institutions that are not the clients' private homes. COMAR 10.09.84.14A requires that clients reside at home to receive personal assistance services. Violators will have consequences. **ONLY FOLLOW CLIENTS APPROVED WORK SCHEDULES IN THEIR PRIVATE HOMES.**

Post the Client Approved Work Schedule on the client's refrigerator if they allow you or where it can be seen in the client's home at all times.

Employee Signature: _____

Date: _____

COMMUNITY HEALTH CARE, INC.

PERSONNEL POLICIES AND PROCEDURES

DATE: January 10, 2025

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EMPLOYEE STATEMENT OF ACKNOWLEDGEMENT

This is to acknowledge that I have received and read a copy of Community Health Care, Inc.'s Personnel Policies and Procedures which has been made available to me on its website. I understand that it provides guidelines and summary information about Community Health Care's personnel policies, procedures, benefits and rules of conduct. I also understand that it is my responsibility to 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.

ACCEPTANCE AND REVIEW OF PERSONNEL POLICIES

I have read, understood and accepted the Personnel Policies of Community Health Care, Inc. I received my copy of the Personnel Policies on _____ day of _____ month of 20 _____.

Employee Name: _____

Position: _____

Date: _____



Employment Eligibility Verification

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

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

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number
<p>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
		<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)				
		If you check Item Number 4., enter one of these:				
		USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance
Signature of Employee				Today's Date (mm/dd/yyyy)		

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

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

Document Title	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	Additional Information				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)	<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

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

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

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

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

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

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	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (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	<ol style="list-style-type: none"> 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 <li style="text-align: center;">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	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (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 <p style="margin-left: 20px;">For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/I-9-central.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.</p>
<p>Acceptable Receipts</p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> o Receipt for a replacement of a lost, stolen, or damaged List A document. o Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. o Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	<ul style="list-style-type: none"> o Receipt for a replacement of a lost, stolen, or damaged List B document. 	OR	<ul style="list-style-type: none"> o 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

Missing Time Acknowledgement

Dear Employee

Effective June 1, 2016 reduced the six (6) unexcused missing times to four (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 participant. DHMH WILL NOT PAY THE PROVIDER'S TIME IF NOT PROPERLY 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 or Email: communityhealthcaremd@verizon.net
2. Have the following information: Client's name, your name, date and time you missed punch with the reason why you were unable to successfully clock in or out.
3. Keep your own records of documentation.
4. YOU ARE ALLOWED FOUR (4) MISSING TIMES PER MONTH.
5. The deadling to submit all missing time in the month is the end of the month.
Example: You cannot submit time for May in July. The agency's deadline for missing time is the 2nd of the following month. That is, time in July must be reported by July 30th so it can be submitted 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 MJUST HAVE YOUR DATES, CLIENT'S NAME AND AMOUNT OF HOURS THAT ARE 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: If it is July and an employee calls about missing time for March, this will take longer to be paid. Office staff has to reach payroll for consultation. Please make sure you follow up about your unpaid days in a timely manner.

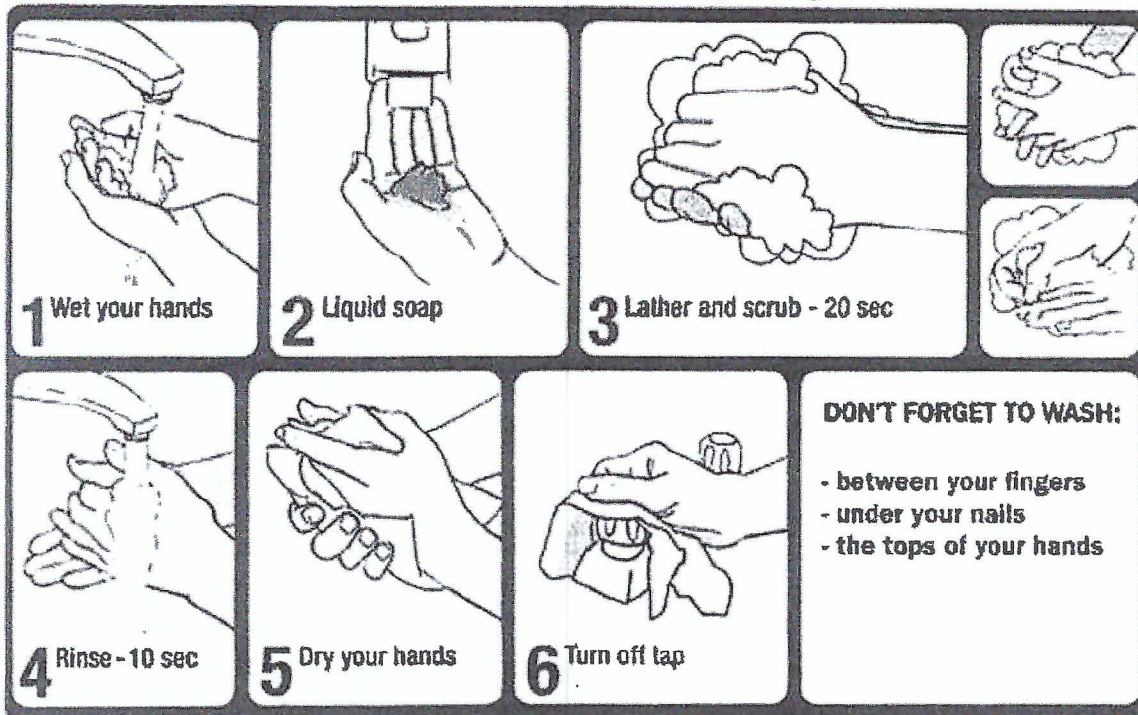
We do not like for our employees to have payroll issues. We want you to be paid for all the hours worked according to client schedule. Therefore, it is important to follow the regulations and policies in order to be paid.

Providers who have more than one client may not clock in for two (2) clients at the same time. This is considered double billing. This is violating COMAR regulations. If you are clocked in for two (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: _____

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



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)