LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS

Copies of Documents

The following documents are required for in processing of new personnel:

- Copy of your Application
- Copy of Social Security Card
- Copy of Driver's License/TX ID
- INS Card (if applicable)
- Documents of employability

Employee Packet Table of Content

Pre-employment

1) Application
2) Identification, social security
3) Verification of employability
4) DPS Computerized Criminal History Verification
5) Statement of Employability (pg. 1-3)
6) Employee Misconduct/Nurse Aide Registry

Employee Packet

1. La Estrella Home Care Attendant Qualification, Requirements, and Acceptance
2. Attendant Emergency Preparedness Training
3. EMR/NAR form
4. Quality Care Training
5. Employee Risk Category
6. Report A N E
7. Personal Attendant Wages Increase
8. Payroll and Wage
9. Check Pick-up Location
10. Payroll Check Mailing Agreement
11. ENHR RPT Form
12. W-4
13. Form I-9 (p.1-2)
14. Form 8850 (p. 1-2)
15. Form ETA 9061 (p. 1-2)
16. Employee Acknowledgement Form
17. Consent for Hepatitis B Vaccination
18. TB Questionnaire
19. Questionnaire for Communicable Disease Control
20. Two Weeks' Notice Letter
21. 90 Day Probation Period
22. Consent to Drug Test
23. Competitive Solicitation Policy
24. Workman's Compensation Disclosure
25. Do's and Don'ts Consent Form
26. Orientation Acknowledgment
27. Training Acknowledgment
28. Employee Benefits Enrollment Information (p. 1-2)
29. Employee Self-Funded Health Plan Enrollment Card (pg. 1-4)
30. Health Insurance Election Form
31. Employee Emergency Contact Form

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Job Description for Personal Care Attendant

Employee Name: _____

Qualification, duties, responsibilities, physical requirements, receipt of employee handbook and job acceptance for Primary Home Care Attendant for a Licensed Personal Care Agency

Qualifications

The Primary Home Care Attendants must meet the following:

1. Be an employee of the agency.
2. Be 18 years or older. If under 18 years of age, must be a high school graduate or enrolled in a vocational educational program.
3. Not be a legal or foster parent of a minor who receives the services; and
4. Not be the spouse of a client who receives the services (this does not apply to family care cases), and
5. Pass a Criminal History, Employee Misconduct Registry Check, Nurse Aide Registry Check, and OIG state/federal check.

Duties and Responsibilities of Primary Home Care Attendant

1. Able to perform tasks listed on attachment and detailed in Title 40, Part I, Chapter 47, Subchapter D, Rule 47.41 Allowable Tasks of the Texas Administrative Code.
2. Must receive orientation in person in the client's home or where services are to be delivered.
3. Be aware of the client's condition on how it affects the performance of tasks.
4. Perform the allowable tasks (provide to you at the client's home prior to initiation of services) according to the schedule determined.
5. Use universal precautions and be aware of safety and emergency procedures.
6. Look for changes to the client's health condition.
7. Report changes to the Client Care Coordinator/Supervisor.
8. Report incidents that affect the client to the Client Care Coordinator/Supervisor.
9. Report hospitalizations of the client to the client Care Coordinator/Supervisor.
10. Comply with the policies and procedures of the agency.
11. Be courteous and respectful to client.
12. Observe the confidentiality rules and do not divulge information to anyone other than the agency staff.
13. Report Abuse, Neglect and Exploitation immediately to the hotline number.
14. Do not provide transportation to the client.

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Physical Requirements

I am able to read, write and comprehend English and/or Spanish. I am able to verbally communicate and have the ability to work a minimum of eight (8) hours per day whether standing, sitting, writing, and speaking and assisting clients with their activities of daily living. I am able to travel to client's residences and assist them physically if needed.

Acceptance

I have read, understand, and accept the position of Primary Home Care Attendant. I meet the qualifications and agree to fulfill the responsibilities listed above, in addition to the allowable tasks, and any others that may be deemed necessary for the safety and care of the client. This agency is a part-time employer and cannot guarantee you a specific number of work hours in a given week. The client's needs are determined by a referral source. The agency is not responsible for your transportation to the client's home, not can we guarantee you employment close to your home. I have been provided with the agency's employee handbook and accept this job.

Orientation

I have been oriented on the agency's policy and procedures. I read and understand La Estrella Home Care Policy and Procedures. I understand that the agency policy and procedures may change and I am responsible for participating or attending training needed for update in any changes. I understand that a copy of the agency's policy and procedure manual is available to me during regular business hours for my review.

_____ _____

Employee's signature Date

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Attendant Emergency Preparedness Training

Date: _____

I, _____ have completed a training module on La Estrella Home Care's policy and procedure on Emergency Preparedness. I understand the agency's procedure in case of an emergency and understand that I will be available for further instruction from our supervisor in case of an emergency. I will assist with providing current contact information for myself and my client.

Training was provided by the HR Clerk/Supervisor

_____.

_____
Employee Signature

_____
HR Clerk/Supervisor's signature

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EMPLOYEE MISCONDUCT • NURSE AIDE REGISTRY INFORMATION FOR EMPLOYEES /VOLUNTEERS

The purpose of the Employee Misconduct Registry (EMR) is to ensure that unlicensed personnel who commits acts of abuse, neglect, exploitation, misappropriation, or misconduct against residents and consumers are denied employments in DADS-regulated facilities and agencies.

As a DADS-regulated agency we are required to check the Employee Misconduct Registry (EMR) and Nurse Aid Registry (NAR) before hiring an individual and on an annual basis to determine if the person is listed in either registry as having committed and act of abuse neglect, exploitation, misappropriation, or misconduct against a resident or consumer and is, therefore, unemployable. You may find regulatory support for this requirements in the rules 40 TAC Ch. 93 and in the law at Texas Health and Safety Code Ch. 250.

I, _____, acknowledge that I have read and understand the above information about the Employee Misconduct in any DADS-regulated agency or facility if I am listed on the EMR/NAR as having committed and act of abuse, neglect, exploitation, misappropriation or misconduct against a resident or consumer.

_____ _____

Signature Date

LA ESTRELLA
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Quality Care

As a provider of La Estrella Home Care we are dedicated to provide quality care to our clients, in order to do this, we request your assistance in keeping good communication from you as the attendant to our clients and to our agency.

We would greatly appreciate your help with the following:

1. Attend all our trainings and or development programs
2. Report any adverse reaction to medications that your client may have.
3. Report illnesses, infections, communicable disease
4. Promote TB screening and Flu shots
5. Report any days missed of work due to illness
6. Report hospitalization
7. Report if your client moves or changes phone number

_____
Print your name

_____ _____
Employee signature Date

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Employee Risk Category

Employee Category I II III (circle one)

Employee Name: _____

Social Security Number: _____

Job Title: _____ Date of Hire: _____

Exposure Potential Tasks:

See Employee Manual Chapter 23- Bloodborne Pathogens

Please initial the following:

_____ As defined in OSHA manual and read by employee.

Personal Protective Equipment to be worn:

_____ As defined in OSHA manual and read by employee

Category Definitions:

1. Task involving **EXPOSURE** to blood, body fluids or tissues.
2. Tasks that routinely involve **NO EXPOSURE** to blood, body fluids or tissues, but employment may require performing unplanned Category I task.
3. Tasks that involve **NO EXPOSURE** to blood, body fluids or tissues.

Employee Signature: _____ Date: _____

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Reporting of Abuse, Neglect and Exploitation

Clients served by the Agency have the right to be cared for in an environment that is safe and free of harm. It is the policy of the Agency not only to expressly prohibit abuse, neglect, and exploitation of the clients by Agency employees, contractors, agents, and affiliates, but also to prevent abuse, neglect, and exploitation and to report, review and investigate all suspected abuse, neglect and exploitation of clients served by the Agency and by persons external to the Agency.

Definitions:

Employee: "means an individual directly employed by an agency, a contractor, or a volunteer".

Abuse: "(A) the negligent or willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical or emotional harm or pain to an elderly or disabled person by the person's caretaker, family member, or other individual who has an ongoing relationship with the person; or (B) sexual abuse of an elderly or disabled person, including any involuntary or nonconsensual sexual conduct that would constitute an offense under Section 21.08, Penal Code (incident exposure)or Chapter 22, Penal Code (assaultive offenses), committed by the person's caretaker, family member, or other individual who has an ongoing relationship with the person."

Neglect: "The failure to provide for one's self goods or services, including medical services, which are necessary to avoid physical or emotional harm or pain of the failure of a caretaker to provide such goods or services."

Exploitation: "The illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with the elderly or disabled person for monetary or personal benefit, profit, or gain without the informed consent of the elderly or disabled person." (This definition includes theft of patient/client medications.)

_____ _____

Employee Signature **Date**

_____ _____

Trainer **Date**

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Name of Employee: _____ Date of Training: _____

Abuse, Neglect, and Exploitation

- ☐ What is Abuse
- ☐ What is Neglect
- ☐ What is Exploitation
- ☐ How to report ANE: 1-800-252-5400 or **www.txabusehotline.org**
- ☐ La Estrella Home Care Policy on Investigating Reports of ANE

****

- ☐ TAC Rule §49.17 (Complaint Procedure)
- ☐ La Estrella Home Care Complaint Procedure & La Estrella Complaint Form

****

- ☐ TAC Rule §97.249 (Self-reportd Incidents of ANE)
- ☐ TAC Rule §97.250 (Agency Investigations)
- ☐ How to report ANE by an agency employee
  - Call 1-800-458-9858
  - Complete Form 3613 (Provider Investigation)
    - Fax Completed Form 3613 & attachment to 1-877-438-5827

****

Questions & Answers

Note: Employee has been provided with a copy of Agency Policies, TAC Rules, and forms discussed above.

Comments:

_____

_____

_____ _____

Employee Signature Date

_____ _____

Trainer Date

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Personal Attendant Wages Increase May 10, 2020

On May 10, 2020, providers must begin paying employed or contracted personal attendants who work in the following programs at least $8 .11an hour, up from the current $8.00 per hour minimum.

- Residential care services
- CLASS habilitation services
- CMPAS personal attendant services
- DAHS attendants
- DBMD residential habilitation, Community First Choice personal assistance services/habilitation (CFC PAS/HAB), chore services, and day habilitation
- HCS supported home living or CFC PAS/HAB
- CLASS habilitation or CFC PAS/HAB
- MDCP respite and Flexible Family Support Services
- PHC, including Family Care and Community Attendant Services
- TxHmL community support or CFC PAS/HAB

Newly employed or contracting attendants hired on or after May 10, 2020, must be notified of the required base wage level within 3 days of being hired.

Print Name

Date

Signature

Page Source: https://casetext.com/regulation/texas-administrative-code/title-1-administration/part-15-texas-health-and-human-services-commission/chapter-355-reimbursement-rates/subchapter-h-base-wage-requirements-for-personal-attendants/section-3557051-base-wage-for-a-personal-attendant

6/15/2021

LA ESTRELLA
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PAYROLL AND WAGE

Employee Name:_____ Phone Number:_____

Address: _____

Date of Hire:_____ Job Title:_____

Date of Birth:_____ Social Security No.:_____

Marital Status:_____ Dependents Claimed:_____

Exempt Employee: ☐ YES ☐ NO Contractor: ☐ YES ☐ NO

Salaried: ☐ YES ☐ NO If YES, enter annual salary: $_____

Pay Rate at Date of Hire:
(Hourly and Visit)

Orientation: _____ Hr / Visit (Circle One)

Regular Rate: _____ Hr / Visit (Circle One)

Overtime: _____ Hr / Visit (Circle One)

Meetings: _____ Hr / Visit (Circle One)

Mileage: _____ Hr / Visit (Circle One)

APPROVED BY:_____

CHANGE OF RATE

DATE	CURRENT PAY RATE AMOUNT $	INCREASED RATE AMOUNT $	EFFECTIVE DATE OF INCREASE	APPROVED BY
	$	$		
	$	$		
	$	$		
	$	$		
	$	$		
	$	$		
	$	$		

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Pick Up Location

Please check where you would like to pick up your check. Pay day is on Friday Between 8:30 a.m. until 4:30 p.m. You must show your ID or DL in order to pick up your check. We will not release any checks without identification. Please keep in mind it is against polity to pick up your check when you are on the clock.

_____ 6315 South Flores

_____2301 San Fernando

_____ _____

Signature Date

LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS
2301 SAN FERNANDO, SAN ANTONIO, TX, 78207
TEL: (210) 436-0533 FAX: (210) 432-5050

Payroll Check Mailing Agreement

I _____ do hereby give La Estrella Home Care permission to mail my payroll check to the address listed on my employee file. I understand that once the pay check has been mailed La Estella is no longer responsible for the delivery by the United States Postal Service. I understand it may take 3-10 business days to receive my check. I further understand that if for any reason I do not receive my check by mail that I will be responsible for any bank charge(s) incurred by the stop payment process. $35 dollars stop payment fee.

_____ (PRINT NAME) _____ (LAST FOUR SS#)

_____ _____

EMPLOYEE SIGNATURE DATE

Please sign if you only want check mailed out!!

Texas Employer New Hire Reporting Form

Submit within 20 calendar days of new employee's first day of work to:
ENHR Operations Center, P.O. Box 149224
Austin, TX 78714-9224
Phone: 1-800-850-6442 FAX: 1-800-732-5015
Online: www.employer.texasattorneygeneral.gov

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A B C 1 2 3

Employer Information

1 Federal Employer ID Number (FEIN):
Please use the same FEIN that appears on quarterly wage reports
7 4 2 9 9 3 7 3 1

2 State Employer ID Number (Optional):

3 Employer Name:
L A E S T R E L L A H O M E C A R E

4 Employer Address (Please indicate the address where the Income Withholding Orders should be sent):
2 3 0 1 S A N F E R N A N D O

5 Employer City (if US):
S A N A N T O N I O

6 State (if US): T X

7 ZIP Code (if US): 7 8 2 0 7 –

8 Province/Region (if foreign):

9 Country (if foreign):

10 Postal Code (if foreign):

11 Employer Telephone (Optional):
2 1 0 4 3 6 0 5 3 3

12 Employer FAX (Optional):
2 1 0 4 3 2 5 0 5 0

13 New Hire Contact Person (Optional):

Employee Information

14 Social Security Number (SSN):

15 Date of Hire (MM/DD/YYYY):

16 Employee First Name:

17 Employee Middle Name:

18 Employee Last Name:

19 Employee Home Address:

20 Employee City (if US):

21 State (if US):

22 ZIP Code (if US): –

23 Province/Region (if foreign):

24 Country (if foreign):

25 Postal Code (if foreign):

26 State Where Employee Was Hired (Optional):

27 Employee DOB (MM/DD/YYYY) (Optional):

28 Employee's Salary (Dollars and Cents) (Optional):

29 Salary Frequency (Check One ONLY) (Optional):
[X] Hourly [ ] Weekly [ ] Biweekly [ ] Semi-Monthly [ ] Monthly [ ] Annually

Form **W-4**
(Rev. December 2020)
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

2021

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 estimator at *www.irs.gov/W4App*, 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 2021 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 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 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)

General Instructions

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 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 **and** you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), 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 2021 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2022.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;

3. Have self-employment income (see below); or

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

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

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

Specific Instructions

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

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

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

If you (and your spouse) have a total of only two jobs, you may instead 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 roughly 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.

CAUTION ***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. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. 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 2021 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.

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 2021 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:
- $25,100 if you're married filing jointly or qualifying widow(er)
- $18,800 if you're head of household
- $12,550 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 possessions 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 Widow(er)

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	$190	$850	$890	$1,020	$1,020	$1,020	$1,020	$1,020	$1,100	$1,870	$1,870
$10,000 - 19,999	190	1,190	1,890	2,090	2,220	2,220	2,220	2,220	2,300	3,300	4,070	4,070
$20,000 - 29,999	850	1,890	2,750	2,950	3,080	3,080	3,080	3,160	4,160	5,160	5,930	5,930
$30,000 - 39,999	890	2,090	2,950	3,150	3,280	3,280	3,360	4,360	5,360	6,360	7,130	7,130
$40,000 - 49,999	1,020	2,220	3,080	3,280	3,410	3,490	4,490	5,490	6,490	7,490	8,260	8,260
$50,000 - 59,999	1,020	2,220	3,080	3,280	3,490	4,490	5,490	6,490	7,490	8,490	9,260	9,260
$60,000 - 69,999	1,020	2,220	3,080	3,360	4,490	5,490	6,490	7,490	8,490	9,490	10,260	10,260
$70,000 - 79,999	1,020	2,220	3,160	4,360	5,490	6,490	7,490	8,490	9,490	10,490	11,260	11,260
$80,000 - 99,999	1,020	3,150	5,010	6,210	7,340	8,340	9,340	10,340	11,340	12,340	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,930	7,130	8,260	9,320	10,520	11,720	12,920	14,120	15,090	15,290
$150,000 - 239,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,230	16,190	16,400
$240,000 - 259,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,270	17,040	18,040
$260,000 - 279,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,870	14,870	16,870	18,640	19,640
$280,000 - 299,999	2,040	4,440	6,500	7,900	9,230	10,470	12,470	14,470	16,470	18,470	20,240	21,240
$300,000 - 319,999	2,040	4,440	6,500	7,940	10,070	12,070	14,070	16,070	18,070	20,070	21,840	22,840
$320,000 - 364,999	2,720	5,920	8,780	10,980	13,110	15,110	17,110	19,110	21,190	23,490	25,560	26,860
$365,000 - 524,999	2,970	6,470	9,630	12,130	14,560	16,860	19,160	21,460	23,760	26,060	28,130	29,430
$525,000 and over	3,140	6,840	10,200	12,900	15,530	18,030	20,530	23,030	25,530	28,030	30,300	31,800

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	$440	$940	$1,020	$1,020	$1,410	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040	$2,040
$10,000 - 19,999	940	1,540	1,620	2,020	3,020	3,470	3,470	3,470	3,640	3,840	3,840	3,840
$20,000 - 29,999	1,020	1,620	2,100	3,100	4,100	4,550	4,550	4,720	4,920	5,120	5,120	5,120
$30,000 - 39,999	1,020	2,020	3,100	4,100	5,100	5,550	5,720	5,920	6,120	6,320	6,320	6,320
$40,000 - 59,999	1,870	3,470	4,550	5,550	6,690	7,340	7,540	7,740	7,940	8,140	8,150	8,150
$60,000 - 79,999	1,870	3,470	4,690	5,890	7,090	7,740	7,940	8,140	8,340	8,540	9,190	9,990
$80,000 - 99,999	2,000	3,810	5,090	6,290	7,490	8,140	8,340	8,540	9,390	10,390	11,190	11,990
$100,000 - 124,999	2,040	3,840	5,120	6,320	7,520	8,360	9,360	10,360	11,360	12,360	13,410	14,510
$125,000 - 149,999	2,040	3,840	5,120	6,910	8,910	10,360	11,360	12,450	13,750	15,050	16,160	17,260
$150,000 - 174,999	2,220	4,830	6,910	8,910	10,910	12,600	13,900	15,200	16,500	17,800	18,910	20,010
$175,000 - 199,999	2,720	5,320	7,490	9,790	12,090	13,850	15,150	16,450	17,750	19,050	20,150	21,250
$200,000 - 249,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$250,000 - 399,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
$400,000 - 449,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,910	21,220	22,520
$450,000 and over	3,140	6,250	8,830	11,330	13,830	15,790	17,290	18,790	20,290	21,790	23,100	24,400

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	$820	$930	$1,020	$1,020	$1,020	$1,420	$1,870	$1,870	$1,910	$2,040	$2,040
$10,000 - 19,999	820	1,900	2,130	2,220	2,220	2,620	3,620	4,070	4,110	4,310	4,440	4,440
$20,000 - 29,999	930	2,130	2,360	2,450	2,850	3,850	4,850	5,340	5,540	5,740	5,870	5,870
$30,000 - 39,999	1,020	2,220	2,450	2,940	3,940	4,940	5,980	6,630	6,830	7,030	7,160	7,160
$40,000 - 59,999	1,020	2,470	3,700	4,790	5,800	7,000	8,200	8,850	9,050	9,250	9,380	9,380
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,850	11,050	11,250	11,520	12,320
$80,000 - 99,999	1,880	4,280	5,710	7,000	8,200	9,400	10,600	11,250	11,590	12,590	13,520	14,320
$100,000 - 124,999	2,040	4,440	5,870	7,160	8,360	9,560	11,240	12,690	13,690	14,690	15,670	16,770
$125,000 - 149,999	2,040	4,440	5,870	7,240	9,240	11,240	13,240	14,690	15,890	17,190	18,420	19,520
$150,000 - 174,999	2,040	4,920	7,150	9,240	11,240	13,290	15,590	17,340	18,640	19,940	21,170	22,270
$175,000 - 199,999	2,720	5,920	8,150	10,440	12,740	15,040	17,340	19,090	20,390	21,690	22,920	24,020
$200,000 - 249,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$250,000 - 349,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
$350,000 - 449,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,900	25,200
$450,000 and over	3,140	6,840	9,570	12,160	14,660	17,160	19,660	21,610	23,110	24,610	26,050	27,350

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►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 10/31/2022

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 Social Security Card
Issuing Authority		Issuing Authority Texas Dept. of Public Safety		Issuing Authority Social Security Administration
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 HR Clerk
Last Name of Employer or Authorized Representative Gonzalez	First Name of Employer or Authorized Representative Lillian	Employer's Business or Organization Name La Estrella Home Care
Employer's Business or Organization Address *(Street Number and Name)* 2301 San Fernando	City or Town San Antonio	State TX ZIP Code 78207

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

Form **8850**
(Rev. March 2016)
Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

▶ Information about Form 8850 and its separate instructions is at *www.irs.gov/form8850.*

OMB No. 1545-1500

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name _____ Social security number ▶ _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

If you are under age 40, enter your date of birth (month, day, year) _____

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if **any** of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  a. Received SNAP benefits (food stamps) for the past 6 months; **or**
  b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months; **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶ _____ **Date** _____

For Employer's Use Only

Employer's name La Estrella Home Care Telephone no. 210-436-0533 EIN ▶ 74-2993731

Street address 2301 San Fernando St.,

City or town, state, and ZIP code San Antonio, TX 78207

Person to contact, if different from above April Morales Telephone no. 210-436-0533

Street address 2301 San Fernando

City or town, state, and ZIP code San Antonio, TX 78207

If, based on the individual's age and home address, he or she is a member of group 4 or 6 (as described under *Members of Targeted Groups* in the separate instructions), enter that group number (4 or 6) . . . . . ▶

Date applicant:

Gave information _____ Was offered job _____ Was hired _____ Started job _____

Under penalties of perjury, I declare that the applicant provided the information on this form on or before the day a job was offered to the applicant and that the information I have furnished is, to the best of my knowledge, true, correct, and complete. Based on the information the job applicant furnished on page 1, I believe the individual is a member of a targeted group. I hereby request a certification that the individual is a member of a targeted group.

Employer's signature ▶ **Title** HR Coordinator **Date**

Privacy Act and Paperwork Reduction Act Notice

Section references are to the Internal Revenue Code.

Section 51(d)(13) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's federal tax return. Completion of this form is voluntary and may assist members of targeted groups in securing employment. Routine uses of this form include giving it to the state workforce agency (SWA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group. This form may also be given to the Internal Revenue Service for administration of the Internal Revenue laws, to the Department of Justice for civil and criminal litigation, to the Department of Labor for oversight of the certifications performed by the SWA, and to cities, states, and the District of Columbia for use in administering their tax laws. 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 section 6103.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

Recordkeeping . . 6 hr., 27 min.

Learning about the law or the form . . . . . 24 min.

Preparing and sending this form to the SWA . . . . . 31 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can send us comments from *www.irs.gov/formspubs*. Click on "More Information" and then on "Give us feedback." Or you can send your comments to:

Internal Revenue Service
Tax Forms and Publications
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send this form to this address. Instead, see *When and Where To File* in the separate instructions.

U.S. Department Of Labor
Employment and Training Administration

Individual Characteristics Form (ICF)
Work Opportunity Tax Credit

OMB Control No. 1205-0371
Expiration Date: March 31, 2023

1. Control No. (For Agency use only)	**APPLICANT INFORMATION** (See instructions on reverse)	2. Date Received (For Agency Use only)

EMPLOYER INFORMATION

3. Employer Name	4. Employer Address and Telephone	5. Employer Federal ID Number (EIN)

APPLICANT INFORMATION

6. Applicant Name (Last, First, MI)	7. Social Security Number	8. Have you worked for this employer before? Yes ☐ No ☐ **If YES,** enter last date of employment: _____

APPLICANT CHARACTERISTICS FOR WOTC TARGET GROUP CERTIFICATION

9. Employment Start Date	10. Starting Wage	11. Position

12. Are you at least age 16, but under age 40? Yes ☐ No ☐
If YES, enter your *date of birth* _____

13. Are you a Veteran of the U.S. Armed Forces? Yes ☐ No ☐
If NO, go to Box 14.
If YES, are you a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (Food Stamps) for at least 3 months during the 15 months before you were hired? Yes ☐ No ☐
If YES, enter name of *primary recipient* _____ and *city and state* where benefits were received _____
OR, are you a veteran entitled to compensation for a service-connected disability? Yes ☐ No ☐
If **YES**, were you discharged or released from active duty within a year before you were hired? Yes ☐ No ☐
OR, were you unemployed for a combined period of at least 6 months (whether or not consecutive) during the year before you were hired? Yes ☐ No ☐

14. Are you a member of a family that received Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) benefits for the 6 months before you were hired? Yes ☐ No ☐
OR, received SNAP benefits for at least a 3-month period within the last 5 months **But** you are no longer receiving them? Yes ☐ No ☐
If YES to either question, enter name of *primary recipient* _____ and city And *state* where benefits were received _____

15. Were you referred to an employer by a Vocational Rehabilitation Agency approved by a State? Yes ☐ No ☐
OR, by an Employment Network under the Ticket to Work Program? Yes ☐ No ☐
OR, by the Department of Veterans Affairs? Yes ☐ No ☐

16. Are you a member of a family that received TANF assistance for at least the last 18 months

before you were hired? Yes ☐ No ☐

OR, are you a member of a family that received TANF benefits for **any** 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended within 2 years before you were hired? Yes ☐ No ☐

OR, did your family stop being eligible for TANF assistance within 2 years before you were hired because a Federal or state law limited the maximum time those payments could be made? Yes ☐ No ☐

If NO, are you a member of a family that received TANF assistance for any 9 months during the 18-month period before you were hired? Yes ☐ No ☐

If YES, to any question, enter name of *primary recipient* _____ and the *city and state* where benefits were received _____.

17. Were you convicted of a felony or released from prison after a felony conviction during the year before you were hired? Yes ☐ No ☐

If YES, enter *date of conviction* _____ and *date of release* _____.

Was this a Federal ____ or a State conviction ____? (Check one)

18. Do you live in an Empowerment Zone or Rural Renewal County (RRC)? Yes ☐ No ☐

19. Do you live in an Empowerment Zone and are at least age 16, but not yet 18, on your hiring date? Yes ☐ No ☐

20. Did you receive Supplemental Security Income (SSI) benefits for any month ending within 60 days before you were hired? Yes ☐ No ☐

21. Are you a veteran unemployed for a combined period of at least 6 months (whether or not consecutive) during the year before you were hired? Yes ☐ No ☐

22. Are you a veteran unemployed for a combined period of at least 4 weeks but less than 6 months (whether or not consecutive) during the year before you were hired? Yes ☐ No ☐

23. Are you an individual who is or was in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation? Yes ☐ No ☐

If YES, what state did you receive unemployment compensation in? _____

(Enter state where UI compensation was received)

24. **Sources used to document eligibility:** (**Employers/Consultants:** List all documentation provided or forthcoming. **For SWA Staff:** List all documentation used in determining target group eligibility and enter your initials and date when the determination was made

I certify that this information is true and correct to the best of my knowledge. I understand that the information above may be subject to verification.

25(a). Signature (See instructions in Box 25.(b) for who signs this signature block)	25.(b) Indicate with a ✓ mark who signed this form: ☐ Employer, ☐ Consultant, ☐ SWA, ☐ Participating Agency, ☐ Applicant, or ☐ Parent/Guardian (if applicant is a minor)	26. Date

LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS

EMPLOYEE ACKNOWLEDGEMENT FORM

The employee handbook describes important information about La Estrella Home Care, and I understand that I should consult the Human Resources Department regarding any questions not answered in the handbook. I have entered into my employment relationship with La Estrella Home Care voluntarily and acknowledge that there is no specified length of employment. Accordingly, either I or La Estrella Home Care can terminate the relationship at will, with or without case, at any time, so long as there is no violation of applicable federal or state law.

Since the information, policies, and benefits described here are necessarily subject to change, I acknowledge that revisions to the handbook may occur, communicated through official notices, and I understand that revised information may supersede, modify, or eliminate existing policies. Only the chief executive officer of La Estrella Home Care has the ability to adopt any revisions to the policies in the handbook.

Furthermore, I acknowledge that this handbook in neither a contract of employment nor a legal document. I have reviewed the handbook and I understand that it is my responsibility to read and comply with the policies contained in this handbook and any revisions made to it.

Employee's Name: _____

Employee's Signature: _____

Date: _____

LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS

Consent for Hepatitis B Vaccination

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus infection. I have been given the opportunity to be vaccinated with the Hepatitis B Vaccine at no cost to myself. However, if I decline the Hepatitis B Vaccination at this time; I understand that I continue to be at risk of acquiring Hepatitis B, a very serious and potentially life-threatening disease. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and i want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination at no charge to me.

I hereby agree to release from liability, all representatives, employees, and agents of the Agency, from any and all costs, expenses, and damages to me related to the acceptance or non acceptance of the Hepatitis B Vaccine.

I understand that if my employment with the Agency is terminated after starting the vaccine series, but before completion of the series, I must pay the cost of any remaining vaccination to complete the series.

[ ] I **DO** want the Vaccine [ ] I Do **NOT** want the Vaccine

[ ] I have received the Hepatitis B Vaccination series but am unable to provide documentation of the vaccination series.

I understand that if I decide to accept the Hepatitis B Vaccination series I have been instructed to go to:

Metro Health Immunization Clinic
345 W. Commerce
San Antonio, TX 78205
Phone: 210-207-8894

I am to bring the receipt containing my name to submit to La Estrella Home Care for reimbursement.

_____ _____ _____

Signature Name – Printed Date

_____ _____

Signature of Agency Representative Date

LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS

Please read and answer the following questions

The purpose of the PPD (Purified Protein Derivative) intradermal skin test is to aid in the detection and diagnosis of tuberculosis or the exposure to tuberculosis. **THIS SKIN TEST WILL NOT BE VALID UNTIL THE RESULTS ARE REPORTED TO AND RECORDED IN THE HUMAN RESOURCES DEPARTMENT. ALL PERSONNEL HEALTH RECORDS ARE KEPT IN CONFIDENTILA FILES.**

1. Have you ever had the disease tuberculosis (TB)? Yes [ ] No [ ]
2. Have you ever had a positive reaction to a TB skin test? Yes [ ] No [ ]
3. Have you ever had an allergic reaction to a TB skin test? Yes [ ] No [ ]
4. Have you ever been immunized against TB with BCG or other? Yes [ ] No [ ]
5. Have you ever received any of the medications used in the treatment of TB (i.e. INH, Rifampin) Yes [ ] No [ ]
6. Have you taken steroids during the last four weeks? Yes [ ] No [ ]
7. Have you had a viral infection during the last four weeks? Yes [ ] No [ ]
8. Have you had any type of vaccine during the past four weeks? Yes [ ] No [ ]
9. Are you pregnant? Yes [ ] No [ ]

TO THE BEST OF MY KNOWLEDGE, THE ABOVE ANSWERS ARE TRUE

Employee Signature: x _____
Date: _____

Manufacturer: _____ Lot Number: _____
Expiration Date: _____ Site: _____
Given By: _____ Date: _____
Results: _____ Nonreactive: _____ Reactive _____ Allergic _____ Induration
date date date date

Chest x-ray referral: _____ to Whom: _____ Date: _____
Results: _____
Referred: _____ Where: _____
Follow up: _____

LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS

Questionnaire for Communicable Disease Control

INITIAL: | | UPDATE: | | EMPLOYEE NAME: _____

1. As far as you know do you currently **have any communicable disease**:
   Yes No Explain: _____

2. Have you ever been diagnosed as <u>having **tuberculosis.**</u> I understand that a "yes" answer means that I need to produce a physician's release to work.
   Yes No Explain: _____

3. Have you been diagnosed as having infectious hepatitis or been exposed to anyone having infectious hepatitis in the last six weeks? I understand that a "yes" answer means that I need to produce a physician's release to work.
   Yes No Explain: _____

4. List any medications that you are currently taking:

   _____
   _____
   _____

5. State any physical limitations or disabilities which may interfere with the performance of your job description:
   Yes No Explain: _____

6. It is highly recommended that employees have regular tuberculosis testing. It is also understood that if I am diagnosed of a having communicable disease, I am required to report the finding to the Texas Department of Health. **I UNDERSTAND THAT I CAN NOT MAKE CLIENT VISITS IF I HAVE A COMMUNICABLE DISEASE.**

Employee Signature: _____ **Date:** _____

LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS

Two Week's Notice Letter

If you are no longer able to work your assigned schedule a minimum of two weeks advance written notice must be provided to the service coordinator and/or field supervisor with a copy sent to Human Resources. If you do not put in your two-week's notice you will be placed on the Do Not Hire List.

_____ _____

Employee's signature Date

LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS

90 Day Letter

I, _____ understand that I have been hired as a temporary employee with a ninety day probation period, beginning on _____, 20_____. Upon completion of the probation period a performance evaluation will be conducted. If permanent employment is to follow the probation period, a written statement signed by the employee and appropriate staff member will be place in the employee file.

Employee's Signature: _____ Date: _____

LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS

Consent to Drug Test

I, _____ understand that La Estrella home Care is a drug-free workplace and that consenting to a drug test is a condition of employment.
I agree that if I am offered and accept a position with the company, I might be required to take a random urine test to screen for the use of illegal drugs.

I acknowledge that I have been informed of the scope of the test, including which drugs are being screened for, as well as the sample collection procedure. I hereby consent to this test.

Furthermore, I am aware that these results will become part of my employment record and that refusing the test of receiving positive results can affect whether I am hires or retained as an employee. I hereby authorize the release of the test results to La Estrella Home Care.

_____ _____

Employee Signature Date

LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS

NON-SOLICITATION AGREEMENT

Non-Solicitation of Clients: You agree that you will not, without the prior written consent of the Employer, at any time during your employment with the Employer or for a period of 2 years from the termination of your employment however caused (whether your employment is terminated by you or the Employer and whether with or without cause or in breach of this Agreement), either individually or through any company controlled by you and either on your own behalf or on behalf of any person competing or endeavouring to compete with the Employer, directly or indirectly solicit, endeavour to solicit or gain the custom of, canvass or interfere with any person who is a client of the Employer as at the date of termination of your employment or use your personal knowledge of or influence over any such client to or for your own benefit or that of any other person competing with the Employer.

Non-Solicitation of Employees: You agree that you will not, without the prior written consent of the Employer, at any time during your employment with the Employer or for a period of 2 years from the date of termination of your employment however caused (whether your employment is terminated by you or the Employer and whether with or without cause or in breach of this Agreement), either individually or through any company controlled by you and either on your behalf or on behalf of any other person competing or endeavouring to compete with the Employer, directly or indirectly solicit for employment, or endeavour to employ or to retain as an independent contractor or agent, any person who is an employee of the Employer as of the date of termination of your employment or was an employee of the Employer at any time during 2 years prior to the termination of your employment.

You further agree that, should you be approached by a person who is or has been an employee of the Employer during the period described above, you will not offer to nor employ or retain as an independent contractor or agent any such person for a period of 2 years following the termination of your employment.

Agreement to Modification of Restrictive Covenants: While the restrictions in the above paragraphs are considered by you and the Employer to be reasonable in all of the circumstances as of the date of this Agreement, it is hereby agreed that if any one or more of such restrictions shall be judged to be void as going beyond what is reasonable in all of the circumstances for the protection of the interests of the Employer, but would be valid if part of the wording thereof were deleted or the period thereof reduced or the range of activities covered thereby reduced in scope, the said reduction shall be deemed to apply with such

modifications as may be necessary to make them valid and effective and any such modification shall not thereby affect the validity of any other restriction contained in this Agreement.

Independent Legal Advice: You agree that you have been advised by the Employer that you should obtain independent legal advice in connection with the terms of this agreement. You confirm that you have either obtained such advice or chosen not to do so and that you fully understand the terms and conditions set out herein and agree to be bound by them.

Copy of Agreement: You acknowledge receipt of a copy of this agreement signed by the Employer.

If you agree with the above, please sign both copies of this letter in the presence of a witness and return one copy to the Employer.

Employee Signature	**Date**
HR Representative/Administrator	**Date**

LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS

Competitive Solicitation Policy

I, _____ understand that the company has a zero tolerance policy regarding client and attendant referrals to competitive agencies.

Should it become apparent that I am involved with referring client prospects, existing clients, or attendants to a competitor agency, this will result in immediate dismissal, and possible recourse through legal means.

Employee's Signature: _____ Date: _____

Workman's Compensation Disclosure

I _____, understand that La Estrella Home Care, does not carry Workman's Compensation Insurance at this time. I am aware that I am completely liable for my own personal coverage.

_____ _____

Signature Date

_____ _____

Signature of Witness Date

LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS

Do's And Don'ts Consent Form

I, _____, have been instructed and understand the responsibilities of my job as an Attendant. If at any time the client is not in compliance I have been instructed to notify agency.

_____ _____

Signature Date

LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS

I _____ understand that I work for La Estrella Home Care, if client no longer wants my services it is my responsibility to contact the agency and request another client. I will be offered another client as long as I'm in good standing with the company. If I do not attempt to call the agency within 3 months it will be considered as a sign of my resignation. I'm aware this is a part-time employer and cannot guarantee me a specific number of work hours in a given week. The client's needs are determined by a referral source. The agency is not responsible for my transportation to the client's home or can guarantee employment close to my home.

_____ _____

Employee Signature Date

LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS

Acknowledgment of Training

I, _____ acknowledge that I attended a training
(Name of Employee)
conducted by La Estrella Home Care on _____. I received training
(Date)
with _____ which covered the processes of the "Vesta
(Name of Trainer)
EVV (Electronic Visit Verification) Devices and Procedures".

The training included:

1. How to clock in and out using Landlines.
2. How to clock in and out using EVV Token Devices.
3. The 1-844-817-9920 number to clock in and out.
4. The EVV Department # (210) 888-0405 for issues clocking in and out and payroll.
5. The consequences of my failure to follow the procedures.
6. How to fill out a dispute form.

I understand my failure to follow the instructions provided in this training and failure to clock in and out could result in me not getting paid for my hours and/or immediate termination.

_____
Print Name of Employee

_____ _____
Signature of Employee Date

_____ _____
Signature of Trainer Date

LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS

Health Insurance Election Form for coverage effective March 1, 2015

The Federal Government has implemented the Affordable Care Act. All persons in the U.S. are required to purchase health insurance either through their employer or individually. To comply with this law, La Estrella is offering a group health insurance plan provided by *Assured Benefits Administrators Insurance Company*.

This plan is available to all full time employees working an average of at least 30 hours a week. This open enrollment only occurs one time a year. If you choose NOT to participate at this time, you will not be able to enroll until next year.

All employees must also complete the Health Insurance Enrollment/Waiver Form and return it before Tuesday February 28th, 2017.

El Gobierno Federal ha puesto en marcha la Ley de "Affordable Care Act". Se requiere que todas las personas en los EE.UU. compran un seguro de salud, ya sea a través de su empleador o de forma individual. Para cumplir con esta ley, La Estrella está ofreciendo un plan de seguro de salud proporcionado *por Assured Benefits Administrators Insurance Company*.

Este plan está disponible para todos los empleados de tiempo completo que trabajan un promedio de al menos treinta horas a la semana. Esta inscripción abierta sólo ocurre una vez al año. Si usted decide no participar en este momento, usted no será capaz de inscribirse hasta el próximo año.

Todos los empleados también deben completar el Formulario de Inscripción/Renuncia de seguro de salud y devolverlo antes del martes 28 de febrero, 2017.

_____ I have received the enrollment information
He recibido la información de inscripción

_____ I acknowledge that as of January 1, 2014 the Affordable Care Act requires me, by law, to cover myself and my dependents in a health insurance plan that meets minimum essential coverage requirements.
Reconozco que a partir del 1 de enero 2014 el Affordable Care Act, me obliga, por ley a obtener cobertura para mí y mis dependientes en un plan de seguro de salud que cumple con los requisitos mínimos de cobertura esenciales.
(Title 1, Sec 1501)

_____ I acknowledge that I have been made aware of health insurance options offered by my employer, La Estrella Home Care, that meets the minimum essential coverage requirements.
Reconozco que he sido hecho consciente de opciones de seguro de salud ofrecidas por mi empleador, La Estrella Home Care, que cumple con los requisitos de cobertura mínima esencial
(Title 1, Sec 1512, 1513).

_____ I have been given the opportunity to participate in the group benefit plan selected by my employer and I **DECLINE** to participate. I understand I will not be able to elect to participate in the group benefit plan until the next annual enrollment unless I experience a qualified change in status.
Se me ha dado la oportunidad de participar en el plan de beneficios de grupo seleccionado por mi empleador y **ME NIEGO** a participar. Entiendo que no podrá optar por participar en el plan de beneficios de grupo hasta la siguiente inscripción anual a menos que experimente un cambio en el estado calificado.

Employee Signature (Firma de empleado)	Social Security Number (Numero de Seg. Social)	Date (Fecha)

Printed Name
(Nombre de empleado)

LA ESTRELLA
HOME CARE AND ADULT DAYCARE CENTERS

Employee Benefits Enrollment Information

For an Effective Date of March 1, 2015

The Federal Government has implemented the Affordable Care Act. All persons in the U.S. are required to purchase health insurance either through their employer or individually. To comply with this law, La Estrella Health Services is offering a group health insurance plan provided by a North America Administrators Insurance Company.

This plan is available to all full time employees working at least 30 hours average per week. This open enrollment only occurs one time a year. If you choose NOT to participate at this time, you will not be able to enroll until next year.

You may qualify for an exemption from the federal penalty. To obtain additional information regarding your shared responsibility under the new law or to get assistance in knowing if you qualify for an exemption, you may contact the following:

Website: www.HealthCare.gov/exemptions

Phone (English/Spanish): 1-800-318-2596

Tax Penalty Estimator: www.healthcareact.com/calculators-penalty.asp

All employees must complete the Health Insurance Enrollment/Waiver Form and return it by Tuesday February 28th, 2017.

ESPAÑOL EN EL OTRO LADO ➡

Lucent Health

Plan Details La Estrella Home Care

April 1, 2021

It's renewal time! Thank you for your loyalty, trust and business. We appreciate your partnership and always enjoy the opportunity to serve you and your client.

Listed below is a summary of the available MEC Plans we offer along with the rates associated with each plan. Please confirm if you wish to continue with the plan(s) you have or if you wish to add additional options for the upcoming renewal.

Minimum Essential Coverage Health Plans				
MEC Plans	**Base MEC**	**MEC Plus**	**Premium MEC**	**Super MEC**
Preventative MEC (63 Items – In-Network only)	**100%**	**100%**	**100%**	**100%**
Drug Formulary	**N/A**	**Up to $50**	**N/A**	**N/A**
Office Visits (Specialists Not Included)	**N/A**	**6 per year with $20 copay**	**6 per year with $20 copay**	**6 per year with $20 copay**
Inpatient				
Day 1 hospital confinement benefit amount per day	**N/A**	**N/A**	**$2,000 per day x 1 day**	**$3,000 per day x 1 day**
Days 2+ hospital confinement benefit amount per day	**N/A**	**N/A**	**$200 thereafter**	**$300 thereafter**
Maximum Benefit	**N/A**	**N/A**	**30 days per year**	**30 days per year**
ICU benefit amount per day	**N/A**	**N/A**	**N/A**	**$300 per day x 10 days**
Accident maximum benefit amount per year includes emergency room for injuries	**N/A**	**N/A**	**$3,000 per year**	**$5,000 per year**
Emergency room for illness only	**N/A**	**N/A**	**$200 per day up to 2 days**	**$250 per day up to 2 days**
CRITICAL ILLNESS[2] Payable for 10 conditions	**N/A**	**N/A**	**$5,000**	**$5,000**
PRESCRIPTION[5]				
Retail - Generic RX copay Mail Order - Generic RX copay Monthly benefit maximum - Individual/Family	**N/A**	**N/A**	**$10** **$30** **$50/$100**	**$10** **$30** **$50/$100**
OTHER SERVICES[6]				
Telephonic Doctor Office Visits	HealthiestYou	HealthiestYou	Teladoc	Teladoc
SupportLinc Employee Assistance through Ternian	**N/A**	**N/A**	Yes	Yes
First Health PPO Discounts	Yes	Yes	Yes	Yes
Rates				
Employee Only	**$56.10**	**$65.10**	**$99.17**	**$114.41**
Employee + Spouse	**$105.10**	**$126.10**	**$185.29**	**$215.77**
Employee + Child(ren)	**80.10**	**$90.10**	**$146.28**	**$174.93**
Employee + Family	**$130.10**	**$145.10**	**$226.40**	**$270.29**

Lucent Health ☐Enrollment / ☐Change Form

Lucent Health

Employer: LA ESTRELLA HOME CARE 100428 **Effective Date:** ____/____/_____ ☐ New Hire ☐Rehire ☐ Full Time ☐ Part Time ☐ Waive ☐ Open Enrollment

Hire Date: ____/____/_____ **Division Num /Location:** _____ ☐Hourly ☐Salary ☐Open Enrollment ☐ Change

Employee Name: _____ _____-_____-_____ ____/____/_____ F or M _____

Last First M.I. Social Security Number Date of Birth Gender Marital

Address: _____ **Contact Phone Num:** _____

Street Address City State Zip

Plan Selection: ☐ Medical (Specify: _____) ☐Employee Only ☐Employee + Spouse ☐Employee + Child(ren) ☐ Employee + Family (Spouse and Children)

REMARKS: _____

Addition of Dependent Coverage: ☐ Spouse ☐Child(ren) ☐ Natural ☐ Adopted ☐ Stepchild (Date of Marriage: _____)

Termination of ALL Dependent Coverage ☐ (Effective Date: _____) Termination of Employee Coverage:_____/_____/_____

Termination of Dependent: ☐Spouse ☐Child(ren) (Effective Date: _____)

Names: _____ _____, _____ Reason: _____

REMARKS: _____

Use the space below to list all eligible **dependents that you are enrolling in coverage**. **Last name is required if different from employee.

If any dependent has a different address, please specify: _____

Name	Date of Birth	Gender	Social Security Number	Relationship	Other Insurance
		M/F		Spouse	Y/N Carrier:
		M/F		Natural / Step / Adopted Child	Y/N Carrier:
		M/F		Natural / Step / Adopted Child	Y/N Carrier:
		M/F		Natural / Step / Adopted Child	Y/N Carrier:

****REQUIRED**** Are you or any dependents covered by any other insurance? ☐ Yes ☐ No Beneficiary: _____ _____%

Other Insurance: _____ Individuals Covered: _____

Group #: _____ Member ID: _____ Insureds Date of Birth:_____/_____/_____

☐ **I hereby apply for the coverage** for which I am now eligible or to which I may become eligible for under the provisions of the Group Plan or Plans issued through North American Administrators/Lucent Health. I authorize deductions from my earnings for my required portion of the premium, if any. I understand that I may not change or revoke these elections until the next Open Enrollment period without a Qualifying Event.

☐ I hereby acknowledge that I have been given the opportunity to elect and **hereby decline coverage.** I understand that I may not change or revoke this waiver until the next Open Enrollment period without experiencing certain Qualifying Events. Reason: _____.

I certify that the above information is true and correct. I hereby authorize all doctors, pharmacists, hospitals, or other institutions rendering care and treatment to furnish NAA/Lucent Health with full information regarding medical treatment (including copies of their records). I also authorize the furnishment of information regarding benefits to which I may be entitled to NAA/Lucent Health. A copy or photocopy of the authorization shall be considered as effective and valid as the original.

Note: Employee must provide any required proof of the Qualifying Event/Permittable Mid-year Event Change to proceed with adding/terming of coverage.

Signature: _____ Date: _____

EMPLOYEE EMERGENCY CONTACT FORM

Name:_____ Date:_____

In case of emergency please notify:

Primary Emergency Contact:

Name:

_____ Relationship:_____

Address:_____

_____

Home Phone: _____ Cell

Phone:_____

Alternate Phone:_____

Secondary Emergency Contact:

Name:

_____ Relationship:_____

Address:_____

_____

Home Phone:_____ Cell

Phone:_____

Alternate Phone:_____

Home Orientation

La Estrella Home Care

H.I.P.P.A.

- CONFIDENTIALITY!!!!
- VERY IMPORTANT
- KEEP INFORMATION TO YOURSELF
- DO NOT GOSSIP ABOUT THE CLIENT

TASKS

- Perform only tasks assigned by case manager and filed supervisor and/or nursing staff
- Do not rush through your assignment
- Do not refuse to do an assigned task

DO NOT....

- Ever intimidate client- client has the right to complain.

You are ....

- Not a nurse

Do Not....

- Give medical advice, suggest they see their doctor
- Suggest healing or home remedies

Do Not....

- Criticize client's appearance or health problems

Do Not ....

- Discuss any issues with the client
- If you are having problems please notify the service coordinator or field supervisor
- If needed ask for a manager

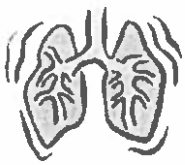
Never....

- Receive personal calls on your cell phone or use client's telephone, unless it is from the office or a life and death emergency

Do Not....

Because ....

- Client may have breathing difficulties or allergies



Do Not ....

- Eat client's food in their home - you make take your own food

Do Not ....

- Take family members with you to client's home

Do Not ....

- Take anything from client's home
- Accept gifts, money clothing, etc.
- Ever borrow or lend money from or to your client.
- Share personal information about yourself, your family, including your telephone number
- Worry you client's about your own personal problems

Respect ....

- Client's belongings
- Do not pull cord from wall, when using vacuum

Do Not ....

- Sell anything to client!!!
- Tickets, products, vitamins, cookies, etc..

Do Not ....

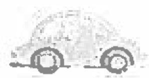
- Discuss your pay with the client and/or their family. Client's are not allowed to call on your behalf.
- Discuss financial issues pertaining to your employer if you are dissatisfied.
- Please notify service coordinator or field supervisor on any issues or concerns you may have.

Do Not ....

- Dress unprofessionally, knee length shorts are allowed in the summer months
- No open shoes or heels
- Dress appropriate

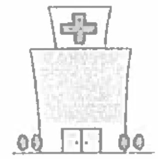
Do Not ....

- Drive your client in your own personal vehicle. This is against company policy. The company is not liable for any accident.



Do Not ....

- Clock/Out when your client in hospitalized
- Client must be home during your scheduled hours



Do Not ....

- Forget to call in to the office on any changes made in your schedule
- Forget to call office to inquire about any changes in your schedule at the end of the day
- Ever leave a client's home unless instructed until your assignment is completed
- Forget to check you voice-mail box for schedules
- Make decisions with out consulting office staff

Do Not ....

- Show disrespect to your co-workers in person or on the telephone
- Repetitively refuse on-call assignments as refusals can lead to termination

EVV Number Clock in/Out

Two ways to clock in /out – Landline or EVV Token

- First, I will explain how to clock in using the Landline

Step 1 - Call 1-844-817-9920 English (Number to clock in/out) or Call 1-844-853-7491 Spanish (Número para reloj de entrada/salida de horas.)

- Step 2 - They system will ask the employee to enter his/her employee ID.
- Step 3 - Client ID.
- Step 4 - After receiving the call time, the employee may hang up and begin providing services

Token Clock in/Out

- When token device is installed in the client's home you are able to clock in/out using your cell phone

Step 1 – Upon arrival at the clients home, locate the Electronic Token.

Step 2 – To begin shift, write down the unique number displayed on the front of the token.

- Step 3 - Call 1-844-817-9920 (English) or Call 1-844-853-7491 (Spanish)
- Step 4 – When prompted, enter Employee and Client ID'S and the unique numbers from the token.

*Each time you clock in [illegible]

EVV Department

- 210-888-0105
- Number to call if you are having issues clocking in/out
- If you want to verify your call went through
- If the token device is not working properly you must report it immediately
- If you have a pay issue you must fill out a pay dispute form within two weeks after payday. The EVV department will investigate your hours. Any owed hours will be issued the next following pay period

Office Number

- 210-436-0533
- Call to speak to service coordinator or field supervisor.
- If you are unable to go to work give us at least 24 hour notice. This will give us enough time to find a floater if needed.
- If you are no longer able to work you must give us a two week notice to stay in good standing with the company. If you do not give a two week notice you will not be rehire able.