COTTAGE HOME CARE, INC.
A CDPAP Company
25 New Bridge Road, Hicksville
Phone: (516) 367-2266
Fax: (516) 367-1067

Personal Assistant Name: _____ **Date:** _____

Consumer's Name: _____ **New : ( ) Yes ( ) No**

Consumer's Address: _____

Consumer's County: ❑Suffolk ❑Nassau ❑Brooklyn ❑Queens ❑Manhattan ❑Bronx ❑Staten Island

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Office Use Only

- ❑ Application
- ❑ W-4 Form
- ❑ Guide to the CDPAP acknowledgement
- ❑ +
- ❑ Health Insurance waiver
- ❑ DOL Acknowledgement of wage rate/payday
- ❑ Transportation Waiver
- ❑ Insurance Card exp. Date _____
- ❑ Live-in agreement
- ❑ I-9 Form
- ❑ Drivers license / US Passport or other: _____
- ❑ Social Security Card (original ID only)
- ❑ Health Assessment
- ❑ PPD Mantoux date: _____
  - ❑ Chest x-ray (if needed)
- ❑ Physical (within the past year)
- ❑ Rubella Titre
- ❑ Rubeola or
- ❑ MMR 1st: _____ 2nd date: _____
- ❑ Hepatitis B Acceptance / Declination Form
- ❑ Drug Test
- ❑ K checks

OFFICE USE ONLY

❑ PA Application Complete Date: _____

❑ Notified _____

COTTAGE HOME CARE, INC.

CONSUMER DIRECTED PERSONAL ATTENDANT PROGRAM

Last Name _____ First Name _____ S.S # _____

Street Address _____ City/Town _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

EDUCATION

High School Name _____ City/Town _____

College _____

HOURS

☐ Days ☐ Nights

☐ Live-In

Mon_____
Tues_____
Wed_____
Thurs_____
Fri_____
Sat_____
Sun_____

PROFESSIONAL TRAINING

Name of School	City & State	Date of Entrance	Graduate Yes/NO	Cert/Degree

SKILLS CHECKLIST (please circle any that apply):

Home Care
Special Diets
Kosher Cooking
Household Maintenance
Laundry
Bed Bath

☐ Denture Care	☐ Non-Sterile Dressing	☐ Orthopedics
☐ Range of Motion	☐ Vital Sign	☐ Diabetes
☐ Transfer Techniques	☐ Urine Testing	☐ Patient Teaching
☐ Hoyer Lift	☐ Geriatrics	☐ Other: _____
☐ Foyer Lift	☐ Child Care	_____
☐ Ostomy Care		

TRANSPORTATION Convenient Transportation to Assignment

Bus/Train/Car? Yes ☐ No ✓ Routes:_____

Valid Licenses? Yes ☐ No ✓

*Do you give permission for a criminal screen to be conducted by the consumer? Yes ☐ No ✓

*I have receive l the Personal Assistant guide to the Consumer Directed Personal Assistance Program.
☐ Yes ✓ No

SIGNATURE: _____ PRINT NAME: _____ DATE: _____

The Consumer Directed Personal Assistance Program (CDPAP) is an alternative to traditional home care. The CDPAP is Medicaid program that enables self-directing individuals or their designated representative, to assume the responsibilities of their own care. The consumer and/or designated representative are responsible for recruiting, interviewing, hiring, training, supervising, scheduling and termination.

What is my role as a Personal Assistant?
As a Personal Assistant you are hired by the consumer and/or designated representative to assist the consumer with their individual needs to live safely in their home within the approved hours authorized by Managed Long Term Care Vendors. By accepting this position, you are agreeing to accept training and supervision at the direction of the consumer or their designated representative. You are responsible to complete the full application and submit the documents needed to work on the CDPAP. You may not submit a time slip or clock in until your application forms are completed and submitted for approval. This approval must be given by Cottage Home Care.

As a Personal Assistant, the Department of Health requires that you pass and submit a physical within the past year, provide proof of immunizations, a PPD or Chest x-ray (if you have a history of a positive PPD), and complete a health assessment. All forms are in the Personal Assistant application. It is your responsibility to keep your compliance up to date yearly.

As a Personal Assistant you may not work on the consumer directed program while the consumer is hospitalized. These hours will not be paid to you by Cottage Home Care, Inc. and will not be billed to NYS Medicaid/Managed Care.

What is the role of Cottage Home Care?
As the Fiscal Intermediary Cottage Home Care will keep a record which consists of the Personal Assistant's original application forms, annual health assessments and the information needed for payroll processing and benefit administration. We act as an employer of record for insurance, unemployment and worker compensation benefits for each Personal Assistant.

Who is my employer?
As a Personal Assistant you are employed by the consumer or their designated representative.

Safety
In the case of accidents that result in injury, regardless of how insignificant the injury may appear, Personal Assistants should immediately notify your consumer or designated representative and Cottage Home Care. Such reports are necessary to comply with OSHA regulations and workers compensation benefits laws.

Live-In
All Personal Assistants who work on a live in case are to be present in the consumer's home for 24 hours each working day. During each live in day, Personal Assistants are to perform tasks in accordance with the verbal and written care plan. Personal Assistants may not work in excess of 13 hours in any day. During each 24 hour day, Personal Assistants are to take eleven hours for personal time which will include hours of sleep, meal breaks and other personal time, remaining on premises at all such times.

Transporting the client
You must provide Cottage Home Care with your current unexpired driver's license and insurance card in order to be authorized to transport your consumer in your car or your consumer's car.

Corporate compliance

Purpose
To ensure Cottage Home Care complies with applicable federal and state laws and regulations and to make a sincere effort to prevent, detect and correct any fraud, abuse or waste in connection with federally funded health care programs and private health plans.

Policy
It is the policy of Cottage Home Care to be in compliance with all federal and state rules, laws and regulations. This includes compliance with all reimbursement rules as required by Medicare, Medicaid, and relevant third party payers. It also includes compliance with relevant federal and state abuse laws including but not limited to the Deficit Reduction Act of 2005 and the Federal and NYS False Claims Act. Compliance issues relating to accurate and truthful documentation, honest and lawful dealing with others and prohibitions against receiving or giving renumeration in turn for referrals are also included. As part of this compliance program, all Personal Assistants are urged to raise any concerns about the accuracy or propriety of any documentation or billing practice or any other compliance issue without concern for retaliation. Such issues may be raised to the Cottage Home Care Compliance Officer @ 929- 386- 0777. All concerns will be reviewed and appropriate action will be taken.

Deficit Reduction Act Of 2005
Cottage Home Care takes fraud and abuse very seriously. It is our policy to provide information to all employees, contractors and agents about the federal and state false claims acts remedies available under these acts and how employees and others can use them, and about whistleblower protections available to anyone who claims a violation of federal or state false claims acts. We also will advise our employees, contractors and agents of the steps the agency has in place to detect health care fraud and abuse.

This act is designed to improve federal and state oversight and enforcement actions against fraud and abuse in the Medicaid program. It requires any entity receiving more than 5 million dollars in Medicaid funds per year must instruct their workforce on the following issues:

- The Federal False Claims Act
- The Federal Program Fraud Civil Remedies Act
- State laws pertaining to civil or criminal penalties for false claims and statements
- Role of such laws in preventing and detecting fraud, waste and abuse
- Whistleblower protections under such laws
- Policies and procedures of Cottage Home Care (provider) for preventing and detecting fraud, waste and abuse

Federal False Claims Act
The False Claims Act is a law that prohibits a person or entity from knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval to the Federal Government and from 'knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal Government. These prohibitions extend to claims submitted to federal healthcare programs, such as Medicare and Medicaid. A person or entity found guilty of violation can be obligated to civil penalty up to 11,000 plus three times the amount of actual damages. A person or entity can also find themselves excluded from the Medicaid programs if found in violation.

How do I get paid?
Federal and state laws require Cottage Home Care to keep accurate records of time worked in order to calculate Personal Assistant pay and benefits. Time worked is all the time actually spent on the job performing assigned duties within the authorized time. You are not permitted to work anywhere else at the same time you are working for your consumer.

All Personal Assistants are required to submit all paperwork to the office weekly by noon on Tuesdays. Paperwork received after 12 noon will be considered late and processed the following week. The payroll cycle is from Sunday 12:00am to Saturday 11:59pm. All paperwork must be signed by the consumer/designated representative and Personal Assistant at the end of each day. Dates, times, signatures and patient information must be filled out correctly. We will not be able to process incomplete paperwork.

Cottage Home Care uses HHA Exchange system to monitor the clock-in and clock-out when working with their consumer. Please make sure to ask for your pin number and instructions on how to use this System. It is prohibited to allow anyone else to use your pin number. Personal Assistants must clock in and out for each shift that is worked. Failure to use the call in system properly will cause a delay in your pay due to the additional processing time needed for timesheets.

(1) PERSONAL ASSISTANT BENEFIT - Compensation and Benefits, Rate of Pay

Your rate of pay varies depending on the contract the consumer is being serviced under and county, state and federal wage laws. Personal Assistants receiving the minimum wage and who qualify for compensated days off will receive 5 days per calendar year based on average hours worked to a maximum of eight hours. This benefit will be paid out to you at the end of your annual term. Compensated days off will not be counted as hours worked for purposes of determining whether overtime premium pay is due to the Personal Assistant.

Health Benefits
Full time personal assistants may enroll in health benefits on the 1st of the month after 90 days of 40 hour a week. If you choose not to enroll after hire you may qualify during open enrollment or if you have a qualifying event. It is your responsibility to fill out the enrollment papers and submit them to Human Resources @ (516) 367-2266

Cottage Home Care pays administrative costs associated with all benefits programs and any Personal Assistant contributions are deducted in installments from Personal Assistant's weekly pay.

(2) ACKNOWLEDGEMENT OF RECEIPT – The personal Assistant Guide to the CDPAP

I have received the Personal Assistant's guide and I have chosen to participate in the CDPAP as a Personal Assistant. I understand that Cottage Home Care is the fiscal intermediary and I am hired, supervised, scheduled and trained by the consumer and/or designated representative.

(3) HEPATITIS B VACCINE DECLINATION (Mandatory)

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 (HBV) infection. I have been given the opportunity to be vaccinated with the hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious 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 series at no charge to me.

(4) PERSONAL ASSISTANT TRANSPORTATION

Please sign one as it applies to you:

( ) I will provide Cottage Home Care with my driver's license and insurance card in order to transport my patient in my car and/or the patient's car.

Signature:_____ Date: _____

( ) I will not be transporting my patient in my car and/or in my patient's car.

Signature:_____ Date: _____

I HAVE READ ALL OF THE ABOVE AND I AGREE TO INFORM COTTAGE HOME CARE IF THERE IS ANY CHANGE IN MY STATUS.

_____

Signature Print Date

AGREEMENT BETWEEN COTTAGE HOME CARE AND LIVE-IN PA's /MEALS & BREAK TIME:

1. All personal assistants (PA's) assigned to live-in cases are to be present in the consumer home for 24 hours each working day.

2. During each live in day, based on a 13 hour day, PA's are to perform tasks in accordance with the verbal or written care plan. PA's may not work in excess of 13 hours in any day and no more than 5 live in days per week.

3. During each 24 hour day, PA's are to take eleven hours for personal time which will include hours of sleep, meal breaks and other personal time, remaining on premises at all such times.

- ♥ 8 hours of sleep time
- ♥ 2 hour meal breaks
- ♥ 1 hour of personal time reading, watching television, etc.

4. If any PA finds it impossible to take the specified breaks from work duties because such times are constantly interrupted by the needs of the patient, she/he must call their coordinator or the administrator at Cottage Home Care.

I understand and I will abide by the agency's rules stated in this agreement regarding time worked on live-in cases. I agree to notify my coordinator if any of the above requirements for sleep and break times do not work and I may be terminated for any false statements for breach of my reporting obligations.

PUNCH IN AND PUNCH OUT

As an employee of Cottage Home Care, I understand the Punch In/Punch Out system. I will punch in at the start of each shift and punch out when the shift is over. I was given clear instructions for the Punch In/Punch Out process by the Cottage Home Care representative before being sent out to work. I understand that this is an agency REQUIREMENT and any failure to do this will directly affect my payroll.

Signature Print Date

ARBITRATION AGREEMENT

This Arbitration Agreement ("Agreement") is made as of_____(date) by and between _____("Employee") and Cottage Home Care, Inc. ("Employer" or "Cottage Home Care").

The parties to this Agreement agrees to arbitrate any and all disputes, claims or controversies ("claims") they may have against each other, including their current and former agents, owners, officers, directors or employees, which have arisen from the employment relationship between Employee and Employer or the termination thereof. Claims covered by this Agreement include, but are not limited to; claims of employment discrimination and harassment under Title VII of the Civil Rights Act, as amended; claims filed with the New York State Division of Human Rights or New York City Commission on Human Rights; the Age Discrimination in Employment Act, as amended; the Americans with Disabilities Act; 42 U.S.C. section 1981; the Employment Retirement Income Security Act; the New York State Labor Laws, including any claims brought by the Employee related to wages; breach of employment contract or the implied covenant of good faith and fair dealing; wrongful discharge but excluding claims for workers' compensation benefits to remedy work related injury or illness. Employee further agrees to waive any collective or class action claims of any matters related to their employment. The parties understand and agree that they are waiving their right to bring such claims to court, including the rights to a jury trial.

The arbitration shall be conducted by a neutral arbitrator, selected by the Employee and Employer or a third-party arbitration provider, in accordance with the National Rules for the Resolution of Employment. The Employer and the Employee will share the arbitrator's fees for the proceedings as well as any room or other charges assessed by the arbiter or arbitration provider. The decision or award of the arbitrator shall be final and binding upon the parties.

Nothing in this Agreement precludes Employee from filing a charge or from participating in an administrative investigation of a charge before any appropriate government agency. However, Employee understands and agrees tht Employee cannot obtain any monetary relief or recovery from such a proceeding. This Agreement shall be governed by and shall be interpreted in accordance with the laws of the State of New York.

A court or other entity construing this Agreement should administer, modify, or interpret it to the extent and such manner as to render it enforceable. If for any reason, this Agreement is declared unenforceable and cannot be administered, interpreted, or modified to be enforceable, the parties agree to waive any right they may have to a jury trial with respect to any dispute or claim relating to employment, termination from employment, or any terms and conditions of employment with the Employer.

Employee understands that s/he would not be hired or maintained as at-will employee by the Employer if s/he did not sign this Agreement. Employee has signed it in consideration of employment by the Employee and acknowledges any past or future dispute as described above will be subject to arbitration. Employee has been advised of his or her right to consult with counsel regarding this Agreement. EMPLOYEE ALSO UNDERSTANDS THAT BY ENTERING INTO THIS AGREEMENT, S/HE IS WAIVING ANY RIGHT TO A TRIAL BY JURY.

EMPLOYEE:	COTTAGE HOME CARE, INC.
_____	_____
Signature	Signature
_____	_____
Date	Date
_____	_____
Print Name	Print Name - Title

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

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.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 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.

	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)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

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

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
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B,

Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		**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 surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

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

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

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

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

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

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

1. Expect to work only part of the year;

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

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

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

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

Specific Instructions

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

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

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

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

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

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

Step 4 (optional).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

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

Single or Married Filing Separately

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

Head of Household

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

NEW YORK STATE | Department of Labor

Notice and Acknowledgement of Pay Rate and Payday Under Section 195.1 of the New York State Labor Law for Home Care Aides Wage Parity and Other Jobs

1. Employer Information

Name: Cottage Home Care Service, Inc

Doing Business As (DBA) Name(s):

FEIN (optional): 113094292

Physical Address: 25 Newbridge rd ste 302
Hicksville, NY 11801

Mailing Address: 25 Newbridge rd ste 302
Hicksville, NY 11801

Phone: 516-367-2266

2. Notice given:

- [x] At hiring
- [ ] Before a change in pay rate(s), allowances claimed or payday

Note: Live-in employees must be paid at least 13 hours for each 24 hour period, provided they receive 8 hours of sleep, with five hours of uninterrupted sleep and 3 hours off for meals. If an employee does not receive 5 hours of uninterrupted sleep, the employee must be paid for all 8 hours. If the employee does not receive meal periods free from duty, the employee must be paid for all 3 hours designated for meals.

3. Employee's Rate(s) of Pay for Each Type of Work Shift:

$_____ per hour for New York
$_____ per hour for _____
$_____ per hour for _____

3a. Wage Parity Rates:

$ 4.09 per hour for regular wage
$_____ per hour for additional wage
$_____ per hour for supplemental wages*

4. Allowances:

- [x] None
- [ ] Tips _____ per hour
- [ ] Meals _____ per meal
- [ ] Lodging _____
- [ ] Other _____

5. Regular Payday: _____

6. Pay is:

- [x] Weekly
- [ ] Bi-weekly
- [ ] Other: _____

7. Overtime Pay Rate(s) for each type of work or shift:

Single Pay Rate: $ 25.50 per hour
This must be at least 1½ times the worker's regular rate with few exceptions.

Wage Parity Pay Rate: $_____ per hour
This must be at least 1½ times the worker's regular rate with few exceptions.

Multiple Pay Rates: $_____ per hour
This must be at least 1½ times the worker's Weighted average of the multiple rates of pay for the week, with few exceptions.

8. Employee Acknowledgement:
On this date, I have been notified of my pay rate, overtime rate (if eligible), allowances, supplements and designated payday. I told my employer what my primary language is.

Check one:

- [x] I have been given this pay notice in English, because it is my primary language.
- [ ] My primary language is English. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

_____
Print Employee Name

_____
Employee Signature

_____
Date

_____
Preparer's Name and Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

Please note: It is unlawful for an employee with protected class status to be paid less than an employee without protected class status, if they are performing substantially equal work. Employers also may not prohibit employees from discussing wages with their co-workers.

*Attach Wage Parity supplement notification page 2.

LS 62 Notice to Wage Parity Home Care Aides - (cont'd)
Benefit Portion of Minimum Rate of Home Care Aide Total Compensation

	Hourly Rate	Type of Supplement	Name & Address of Provider	Agreement/ Plan Information
Supplement Number	*$ XXX*	*(Pension, Welfare, or Other)*	*Insert Name and Address of Company or Organization Providing Benefit*	*Identify plan or agreement that creates the benefit, e.g., Union Local No. 1 Collective Bargaining Agreement or Insurance Company X Benefit Plan*
Supplement Number 1				
Supplement Number 2				
Supplement Number 3				

**If wage supplements are paid as a single payment owed to multiple Taft-Hartley multiemployer plans, list only the following: (1) the total paid for the supplement or benefit package; (2) the types of benefits included in the package, e.g., pension, health and welfare, or other; (3) the name and address of the entity to whom payment is sent; and (4) the relevant CBA or letter of assent as the agreement.*

List any additional benefits and attach listing to this document.

Copies of the above listed agreements or summaries may be obtained by:

_____

Employee Acknowledgement:

On this day I have been notified of my pay rate, overtime rate, allowances, supplements/benefits, and designated payday provided on this form (LS 62) attached and this addendum on the date given below.

My primary language is _____. I have been given this notice in my primary language ☐ Yes ☐ No.

Employee Name (Print): _____

Employee Signature: _____ Date Signed: _____

Preparer's Name and Title: _____

NEW YORK STATE | Department of Labor

Notice and Acknowledgement of Pay Rate and Payday Under Section 195.1 of the New York State Labor Law for Home Care Aides Wage Parity and Other Jobs

1. Employer Information

Name: Cottage Home Care Services, Inc.

Doing Business As (DBA) Name(s):

FEIN (optional): 113094292

Physical Address: 25 Newbridge rd ste 302
Hicksville, NY 11801

Mailing Address: 25 Newbridge rd ste 302
Hicksville, NY 11801

Phone: 516-367-2266

2. Notice given:

- [x] At hiring
- [ ] Before a change in pay rate(s), allowances claimed or payday

Note: Live-in employees must be paid at least 13 hours for each 24 hour period, provided they receive 8 hours of sleep, with five hours of uninterrupted sleep and 3 hours off for meals. If an employee does not receive 5 hours of uninterrupted sleep, the employee must be paid for all 8 hours. If the employee does not receive meal periods free from duty, the employee must be paid for all 3 hours designated for meals.

3. Employee's Rate(s) of Pay for Each Type of Work Shift:

$_____ per hour for Long Island, Westchester
$_____ per hour for _____
$_____ per hour for _____

3a. Wage Parity Rates:

$3.22 per hour for regular wage
$_____ per hour for additional wage
$_____ per hour for supplemental wages*

4. Allowances:

- [x] None
- [ ] Tips _____ per hour
- [ ] Meals _____ per meal
- [ ] Lodging _____
- [ ] Other _____

5. Regular Payday: _____

6. Pay is:

- [x] Weekly
- [ ] Bi-weekly
- [ ] Other: _____

7. Overtime Pay Rate(s) for each type of work or shift:

Single Pay Rate: $25.50 per hour
This must be at least 1½ times the worker's regular rate with few exceptions.

Wage Parity Pay Rate: $25.50 per hour
This must be at least 1½ times the worker's regular rate with few exceptions.

Multiple Pay Rates: $_____ per hour
This must be at least 1½ times the worker's Weighted average of the multiple rates of pay for the week, with few exceptions.

8. Employee Acknowledgement:
On this date, I have been notified of my pay rate, overtime rate (if eligible), allowances, supplements and designated payday. I told my employer what my primary language is.

Check one:

- [x] I have been given this pay notice in English, because it is my primary language.
- [ ] My primary language is English. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

_____
Print Employee Name

_____
Employee Signature

_____
Date

_____
Preparer's Name and Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

Please note: It is unlawful for an employee with protected class status to be paid less than an employee without protected class status, if they are performing substantially equal work. Employers also may not prohibit employees from discussing wages with their co-workers.

*Attach Wage Parity supplement notification page 2.

LS 62 Notice to Wage Parity Home Care Aides - (cont'd)
Benefit Portion of Minimum Rate of Home Care Aide Total Compensation

	Hourly Rate	Type of Supplement	Name & Address of Provider	Agreement/ Plan Information
Supplement Number	*$ XXX*	*(Pension, Welfare, or Other)*	*Insert Name and Address of Company or Organization Providing Benefit*	*Identify plan or agreement that creates the benefit, e.g., Union Local No. 1 Collective Bargaining Agreement or Insurance Company X Benefit Plan*
Supplement Number 1				
Supplement Number 2				
Supplement Number 3				

**If wage supplements are paid as a single payment owed to multiple Taft-Hartley multiemployer plans, list only the following: (1) the total paid for the supplement or benefit package; (2) the types of benefits included in the package, e.g., pension, health and welfare, or other; (3) the name and address of the entity to whom payment is sent; and (4) the relevant CBA or letter of assent as the agreement.*

List any additional benefits and attach listing to this document.

Copies of the above listed agreements or summaries may be obtained by:

_____

Employee Acknowledgement:

On this day I have been notified of my pay rate, overtime rate, allowances, supplements/benefits, and designated payday provided on this form (LS 62) attached and this addendum on the date given below.

My primary language is _____. I have been given this notice in my primary language ☒ Yes ☐ No.

Employee Name (Print): _____

Employee Signature: _____ Date Signed: _____

Preparer's Name and Title: _____

COTTAGE HOME CARE

SERVICES

25 Newbridge Road, Ste#302, Hicksville, NY 11801

Tel:516.367.2266 * Fax:516.367.1067

DIRECT DEPOSIT AUTHORIZATION

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____

Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: ☐ $ _____ ☐ _____ % or ☐ Entire Paycheck

Type of Account: ☐ Checking ☐ Savings (Check One)

Attach a voided check for each bank account to which funds should be deposited (if necessary)

_____ [***Cottage Home Care Services***] is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee's Signature: _____

Date: _____