United at Home, LLC

3217 Lemay Ferry Rd, Saint Louis, MO 63125

(314) 329-6099 Unitedathome@yahoo.com

PLEASE READ THESE INSTRUCTIONS FIRST.

WE WILL NOT PROCESS YOUR APPLICATION IF INFORMATION IS MISSING.

Do not use white out, erasable ink, red ink, or pencil on the application or other documents. Complete the employment applications in its entirety. We will NOT process incomplete applications.

- ☐ We required address and phone numbers in your employment history.
- ☐ As a requirement for the state of Missouri, all potential personal care Attendants must complete the Family Care Safety Worker Registration form and background screening.
- ☐ Please bring in a photocopy of your social security card along with a one-time fee $13.25 in the form of checks or money order made payable to Department of Health and Senior Services. (Fees not required if already registered.)
- ☐ Initial each part of the Personal Care Attendant Rights & Responsibility.
- ☐ Complete the I-9 form – This form CANNOT contain errors or mark though corrections.
- ☐ Bring with you/provide 2 forms of proper and current identifications on the I-9 List of Acceptable Forms page. Please make sure that both forms on identifications have the same name on them.

We urged Consumers to choose a Personal Care Attendant with a clean background.

If the screening via Family Care Safety Worker has findings, you may complete a Good Cause Waiver and submit all required documents to the Department of Health and Senior Services in order to become considered for hired. They will review the Good Cause Waiver and make the decision whether you will become eligible for hired. You may not work for any Consumer until the Good Cause Waiver has been reviewed.

Please note: A Personal Care Attendant is not an employee of UAH or the state of Missouri or any department, unit, agency, or subdivision therefore on your application, please do not indicate that United at Home is your employer, unless you held professional position (i.e. Administrative Assistant, United at Home Specialist.)

I verify that I have fully read and understand the conditions described in this instruction sheet. Additionally, I understand that I am legally mandated to disclose any criminal activity in my background. I will not hold UAH legally responsible, in any manner, if I begin working for any CDS consumer without clearance from a staff member. I understand that I am required to complete all pre-employment documentation and receive approval from Services for UAH before I am considered an employee. Hours worked without approval of UAH, will not be paid by UAH.

_____

Applicant Signature Date

EMPLOYMENT APPLICATION

First Name_____Last Name_____

Address_____

City_____ State _____ Zip Code_____

Home Phone _____Cell Phone_____

Date of Birth_____Gender_____Social Security_____

Do you Smoke? Yes_____No_____ Are you willing to work for people who smoke? Yes_____ No_____

o you meet the physical and mental demands required to perform specific tasks of the consumer; agree to maintain confidentiality of personal
hedical information, are emotionally mature and dependable; are able to handle emergency saturation; and are not the CDS consumer's
e? Yes_____No_____

Have you ever been convicted of crime other than traffic related? Yes_____No_____

If you answered yes, by law you are required to disclose all criminal convictions, finding of guilt, pleas of no contest, except minor traffic violations. If you do not have a criminal background, please indicate that you have a clear criminal background

_____

_____

Have you ever been listed on EDL?
Yes_____No_____Reason_____

Have you ever applied for a Good Cause Waiver?
Yes_____No_____When?_____Why?_____+_____

- ✓ *Please ask us how to complete a Good Cause Waiver when criminal history is disclosed*

Are you registered with the Family Care Safety Registry? Yes____No____ (If no, a payment of $12 is required)

Do you have a valid driver's license? Yes____No____ Do you own reliable transportation? Yes_____No_____

Can you read, write and follow directions? Yes_____No_____

Do you prefer working with male, females or either?_____

Have you identified a consumer to work for? Yes_____No_____ If yes, whom:_____

Has someone asked you to work for them? Yes_____No_____ If yes, whom:_____

Are you related to the Consumer? Yes_____ No_____ If yes, state the relationship_____

What experience do you have caring for children, individuals with chronic illness or individuals with diabetes?_____

Have you ever had contacts with us before?_____

How did you hear about this position?_____

EMPLOYMENT HISTORY

List the last 5 years of employment with most recent first.

1. Company Name:_____

Address:_____

Dates Employed:_____Position Held: _____

Duties:_____Reason for leaving_____

_____

2. Company Name: _____

Address:_____

Dates Employed:_____Position Held: _____

Duties:_____Reason for leaving_____

_____

3. Company Name:_____

Address:_____

Dates Employed:_____Position Held: _____

Duties:_____Reason for leaving_____

_____

Do we have permission to contact your past employers?_____

REFERENCE: LIST THREE PERSONAL REFERENCES NOT ARE RELATED TO YOU.

Name:_____**Relationship:**_____

Address_____**Phone:**_____

_____

Name:_____**Relationship:**_____

Address:_____**Phone:**_____

_____

Name:_____**Relationship:**_____

Address:_____**Phone:**_____

Acknowledgement:

I certify the answers herein are true and accurate to the best of my knowledge and I hereby authorize UAH to perform pre-employment criminal record checks for employment purposes only. I hereby give consent for UAH to perform a closed records check pursuant to Section 610.120 RSMO. I agree that UAH is not liable for any wages for any hours worked until after a background screening via the FCSR has been performed and the results are clear and, if applicable, my Good Cause Waiver is in good standing. Additionally, I understand that if there is any form of background information disclosed during my employment, my employment shall be immediately terminated

_____ _____

Signature of Applicant Date

United at Home is an equal opportunity/affirmative action institution. All qualified applicants will be considered without regard to race, gender (sex), religion, veteran status, disability, age, sexual orientation and national origi

EMPLOYMENT CONTRACT

EMPLOYER (Consumer)_____

EMPLOYEE (Attendant)_____

WORK SCHEDULE	**TIME IN**	**TIME OUT**
Sunday _____	_____	_____
Monday _____	_____	_____
Tuesday _____	_____	_____
Wednesday _____	_____	_____
Thursday _____	_____	_____
Friday _____	_____	_____
Saturday _____	_____	_____

SALARY: ATTENANT/EMPLOYEE WILL BE PAID $9.00 PER HOUR. PAYROLL IS WEEKLY DUTIES TO BE PERFORMED

Dressing/Grooming	Toilet Bladder/Routine	Treatments	Cooking
Bathing/Hygiene	Asst. Toilet	Clean Main Equipment	Tidy & Dust
Daily Medication	Asst. Transfer Device	Clean Bath	Clean Floor
Medication Refills	Turning/Positioning	Make Bed	Trash
Errand/Shopping	Meal Prep/Eating	Change Lien	Clean Kit
Essential Correspond	Passive ROM	Laundry	Medical Appointment
Ostomy Hygiene	Other	Wash Dishes	Catheter Care

THERE ARE NO OVERTIME OR FRINGE BENEFITS WITH THIS POSTION. BY SIGNING THIS FORM THE EMPLOYER AND EMPLOYEE AGREE TO ALL THE ABOVE MENTIONED TERMS.

SIGNATURE

EMPLOYER (Consumer):_____DATE_____

EMPLOYER (Consumer):_____DATE_____

EMPLOYEE (Caregiver):_____DATE_____

PERSONAL ATTENDANT RIGHTS AND RESPONSIBILITIES

Duties of the Personal Attendant include, but are not limited to, the following:

- Personal Attendant agrees to assist the Employer by providing the services and performing the activities specified in Employer's service plan;
- Personal Attendant agrees to protect the health and welfare of the Employer by providing authorized services in accordance with the policies and standards of the Missouri Department of Health and Senior Services;
- Personal Attendant agrees to provide Personal Attendant Services as specified in the Employer's service plan on a schedule mutually agreed upon between the employer and the personal care attendant;
- Personal Attendant agrees to participate in training in providing services, including training in performing any allowable health activities, as required by the Employer and as specified in the Employer's service plan;
- Personal Attendant agrees to confidentially maintain all information regarding the Employer and to respect the Employer's privacy;
- Personal Attendant agrees to pay all required federal, state, and/or local wage and/or income taxes levied against the Personal Attendant's wages. The Personal Attendant agrees to cooperate with the Employer and the Employer's Fiscal Agent in providing information needed to comply with all income and unemployment taxation laws and regulations;
- Personal Attendant understands that this agreement does not guarantee employment or payment of wages for any time period;
- Personal Attendant understands that the Personal Attendant is employed by the Employer and not by United at Home;
- Employer's property is not to be used for the Personal Attendant's personal use, unless mutually agreed upon by both parties prior to use of property. All private matters discussed during working times shall be kept confidential; and
- Personal Attendants are to be punctual, neatly dressed, and respectful of all family members.
- Personal Attendants have the right to be treated with respect and spoken to appropriately.
- Personal Attendants have all of the rights afforded by Missouri and Federal employment laws where applicable.
- In the event of illness, emergency, or incident preventing Personal Attendant from providing scheduled service to the Employer, the Personal Attendant agrees to notify the Employer as soon as possible so that the Employer can obtain assistance from someone else;
- Personal Attendants must give UAH and Consumer at least 7 days prior noticed before terminating work. If less than 7 days noticed is given; Personal Attendants will be charge a fee. (20% of total paycheck)
- Personal Attendants are required to report to the Adult Abuse and Neglect hotline on any suspicion of abuse or neglect of a consumer.
- Personal Attendant must notify UAH as soon as possible when Consumer is admitted to the hospital or goes out of town. Attendants will not be compensated during the duration of these occurrences.

_____

Attendant Signature Date

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
FAMILY CARE SAFETY REGISTRY

WORKER REGISTRATION

FCSR USE ONLY

Register online at www.health.mo.gov/safety/fcsr OR mail this form, copy of Social Security card, and payment to Missouri Dept. of Health and Senior Services, Fee Receipts, PO Box 570, Jefferson City, MO 65102.

REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)

- ☐ Adoptive Parent
  Agency Name: _____
- ☐ Child Care
- ☐ Foster Parent/Family Member of Foster Parent
  County Office: _____
- ☐ Hospital
- ☑ Long Term Care/Personal Care (Please choose subcategory at right ▸.)
- ☐ Mental Health/Psychiatric Hospital
- ☐ Voluntary *(Select voluntary if no other registration type applies.)*

A one-time registration fee of **$14.00** applies to all categories except Foster Parents. Foster Parents must list the Children's Division county office.

Register only once. If you believe you have already registered, check our website at www.health.mo.gov/safety/fcsr or call, toll free, 866-422-6872.

Long Term Care / Personal Care Subcategories
(Complete if LTC/PC selected at left.)

- ☐ Adult Day Care
- ☐ Assisted Living Facility
- ☐ Hospice
- ☐ Hospital LTAC/Swing Bed
- ☐ Mental Health – Residential Facility/ICF
- ☐ Nursing Facility/Skilled Nursing
- ☐ Personal Care – Home Health
- ☑ Personal Care – In-Home Services
- ☑ Personal Care – Consumer Directed Services/Center for Independent Living
- ☐ Personal Care – HCY/PDW/DDD/Other

SOCIAL SECURITY NUMBER (Mail copy of card with form.)

– –

PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX (JR., SR., II, III)

MAIDEN NAME (IF APPLICABLE)	PRIOR NAMES USED (IF APPLICABLE, LIST FIRST AND LAST NAMES.)	DATE OF BIRTH (MM-DD-YYYY)	GENDER
			☐ M ☐ F

CONTACT INFORMATION

MAILING ADDRESS (ENTER YOUR STREET ADDRESS OR POST OFFICE BOX. THIS ADDRESS MUST BE DIFFERENT FROM EMPLOYER ADDRESS.)

CITY	STATE	ZIP CODE	COUNTY

TELEPHONE	EMAIL ADDRESS (REQUIRED)	COUNTRY (COMPLETE ONLY IF OUTSIDE U.S.)

EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

☐ My current/potential child care, long term care or mental health care employer is:

EMPLOYER NAME

EMPLOYER ADDRESS

EMPLOYER CITY	STATE	ZIP

EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE

☐ No Employer, because I am a(n):

- ☐ Adoptive Parent
- ☐ Foster Parent/Family Member
- ☐ Home Child Care Provider
- ☐ Private Pay/Private Duty
- ☐ Student
- ☐ Volunteer
- ☐ Other (Explain:)

REGISTRATION AGREEMENT

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requester of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT	DATE OF SIGNATURE (MUST BE WITHIN SIX MONTHS OF SUBMISSION.)

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

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

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

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion 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)*

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

STOP ***Employer Completes Next Page*** STOP

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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

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

3-D Barcode
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	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy):*	Print Name of Employer or Authorized Representative:

Form
MO W-4

MISSOURI DEPARTMENT OF REVENUE

Employee's Withholding Certificate

Reset Form | Print Form

This certificate is for income tax withholding and child support enforcement purposes only. Type or print.

Employee

Full Name		Social Security Number
Home Address (Number and Street or Rural Route)	**City or Town**	**State** / **ZIP Code**

1. Filing Status: Check the appropriate filling status below.
   - ❒ Single or Married Spouse Works or Married Filing Separate
   - ❒ Married (Spouse does not work)
   - ❒ Head of Household

2. Additional withholding: If you expect to have a balance due (as a result of interest income, dividends, income from a part-time job, etc.) on your tax return, you may request your employer to withhold an additional amount of tax from each pay period. To calculate the amount needed, divide the amount of the expected tax by the number of pay periods in a year. Enter the additional amount to be withheld each pay period on line 2. 2

3. Reduced withholding: If you expect to receive a refund (as a result of itemized deductions, modifications or tax credits) on your tax return, you may direct your employer to only withhold the amount indicated on line 3. Your employer will not use the standard calculations for withholding. If you designate an amount that is too low, it could result in you being under withheld. To calculate the amount needed, divide the amount of your expected tax by the number of pay periods in a year. Enter the amount to be withheld instead of the standard calculation. If no amount is indicated on line 3, the standard calculations will be used. 3

4. Exempt Status: Select the appropriate reason you are claiming an exemption from withholding below and indicate EXEMPT on line 4. 4

   - ❒ I am exempt because I had a right to a refund of all Missouri income tax withheld last year and expect to have no tax liability this year. A new MO W-4 must be completed annually if you wish to continue the exemption.
   - ❒ I am exempt because I meet the conditions set forth under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act and have no Missouri tax liability.
   - ❒ I am exempt because my income is earned as a member of any active duty component of the Armed Forces of the United States and I am eligible for the military income deduction.

Signature

Under penalties of perjury, I certify that the information provided on this form is true and accurate.

Employee's Signature (Form is not valid unless you sign it)	Date (MM/DD/YYYY)
	__ __ / __ __ / __ __ __ __

Employer

Employer's Name	Employer's Address	
City	**State**	**ZIP Code**
Date Services for Pay First Performed by Employee (MM/DD/YYYY)	**Federal Employer I.D. Number**	**Missouri Tax Identification Number**
__ __ / __ __ / __ __ __ __		

Notice To Employer:

Within 20 days of hiring a new employee, send a copy of Form MO W-4 to the Missouri Department of Revenue, P.O. Box 3340, Jefferson City, MO 65105-3340 or fax to (573) 526-8079.
Please visit **http://dss.mo.gov/child-support/employers/new-hire-reporting.htm** for additional information regarding new hire reporting.

Notice to Employee:

Return completed form to your Employer. Consider completing a new Form MO W-4 each year and when your personal or financial situation changes. Visit our online withholding calculator **https://mytax.mo.gov/rptp/portal/home/withholding-calculator.**

Items to Remember:

- Employees must complete a new form if their filing status changes or to adjust the amount of withholding.
- If you are claiming an "Exempt" status due to the Military Spouses Residency Relief Act you must provide one of the following to your employer: Leave and Earnings Statement of the non-resident military servicemember, Form W-2 issued to the nonresident military servicemember, a military identification card, or specific military orders received by the servicemember. You must also provide verification of residency such as a copy of your state income tax return filed in your state of residence, a property tax receipt from the state of residence, a current drivers license, vehicle registration or voter ID card. For additional assistance in regard to Military, visit the department's website **https://dor.mo.gov/military/.**
- Additional information can be found at **https://dor.mo.gov/business/withhold/**.

Mail to: Taxation Division
P.O. Box 3340
Jefferson City, MO 65105-3340

Phone: (573) 522-0967
Fax: (573) 526-8079

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

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

Step 3: Claim Dependents

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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