

EVAN HOME CARE LLC

APPLICATION FOR

- EMPLOYMENT
- INDEPENDENT CONTRACTOR

Evan Home Care LLC, (the "Company"), is an equal opportunity/affirmative action employer and contractor. All qualified applicants will be considered without regard to age, race, color, sex, religion, nation origin, marital status, ancestry, citizenship, veteran status, sexual orientation or preference, or physical or mental disability.

New Hire Demographic Form

Personal Information:

Name: _____
 First _____ Middle _____ Last _____

Date of Birth: _____ Sex: Male Female Social Security # _____ - _____ - _____
 MM DD YYYY

Address: _____ Apt. Number: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

DL #: _____ State: _____ Issued: _____ Exp Date: _____
 MM DD YYYY

Citizenship Status:

Citizen Non-Citizen National of US Non-Resident Alien Perm Resident

Alien Registration Number: _____ EAD Number: _____
 (Employment Authorization Document)

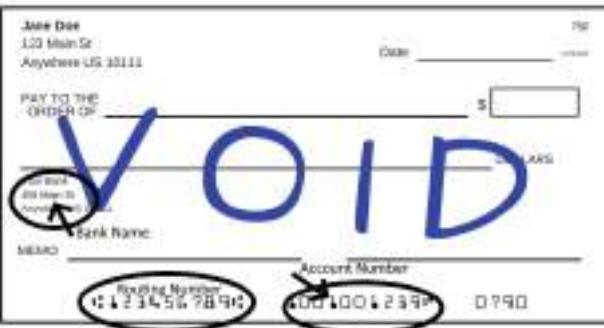
EAD Expiration Date: _____
 MM DD YYYY

Financial Information:

Bank for direct deposit: _____

Routing Number: _____

Account Number: _____



Employer Signature: _____ Today Date: _____
 MM DD YYYY

PERSONAL

Last Name	First	Initial	Social Security #
Other Name(s) Used			Date of Birth
Address			Cell Phone # Home Telephone # ()
Position Applied For	Salary Desired	Email Address:	
Referred By			
Are you at least 18 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No		If under 18, do you have a work permit?	

EDUCATION

Circle Highest Grade Completed:

High School	9	10	11	12
College, Trade or Business	1	2	3	4
Graduate Studies	_____			

School	Address	Major Studies	Degree, Diploma, License or Certificate
High School			
College/University			
Vocational, Business, Other			

List Any Professional Designations and Licenses, including license numbers and expiration dates

Other Special Knowledge, Skills or Qualifications

For Clerical Applicants Only:

Do you type? Yes No If yes, WPM:

Computer Skills (Hardware/Software)

EMPLOYMENT HISTORY

List all employed and/or contracted positions for the past 10 years, starting with the most recent position. All information **must** be completed. You may attach a resume in place of completing the required information.

Employed From / / /	Employer Name	Supervisor Name	Starting Salary
Employed Until / / /	Employer Address	Supervisor Phone #	Ending Salary

Job Title Reason for Leaving

Duties & Responsibilities

Employed From / / /	Employer Name	Supervisor Name	Starting Salary
Employed Until / / /	Employer Address	Supervisor Phone #	Ending Salary

Job Title Reason for Leaving

Duties & Responsibilities

Employed From / / /	Employer Name	Supervisor Name	Starting Salary
Employed Until / / /	Employer Address	Supervisor Phone #	Ending Salary

Job Title Reason for Leaving

Duties & Responsibilities

Employed From / / /	Employer Name	Supervisor Name	Starting Salary
Employed Until / / /	Employer Address	Supervisor Phone #	Ending Salary

Job Title Reason for Leaving

Duties & Responsibilities

(Use back of page if more space is needed)

GENERAL

Yes No

- May we contact your current employer for references?
- If hired as an employee, will you be able to work overtime?
- Will you be able to perform the essential job functions for the position you are applying for with or without reasonable accommodation?
- Have you ever been convicted of a crime, excluding misdemeanors and summary offenses, which has not been annulled, expunged or sealed by court? (A "yes" response does not automatically disqualify your application.)

CERTIFICATION & AUTHORIZATION

The above information is true and correct. I understand that, in the event of my employment by or contract with the Company, I shall be subject to dismissal if any of the information I have given in this application is false or misleading, or if I have failed to give any information herein requested, regardless of the time elapsed after discovery.

I authorize the Company to inquire into my educational, professional and past employment or contract history references as needed to research my qualifications for this position. I hereby give my consent to any former employer to provide employment-related information about me to the Company and will hold the Company and my former employer harmless from any claim made on the basis that such information about me was provided or that any employment or contracting decision was made on the basis of such information.

I understand that nothing in this employment application, the granting of an interview or my subsequent association with the Company, is intended to create an employment contract between myself and the Company, unless a written contract is signed by me and the Company. On the contrary I understand and agree that, if hired/contracted, my employment/contract will be terminable at will and may be terminated by me or the Company at any time and for any reason. I understand that no person has any authority to enter into any agreement contrary to the foregoing.

If employed, I will be required to provide original documents, which verify my identity and right to work in the United States under the Immigration Reform and Control Act (IRCA) of 1986. The document(s) provided will be used for completion of Form I-9.

I hereby acknowledge that I have read and agree to the above statements.

Signature

Date

PROVIDER APPLICANT REFERENCE FORM

The applicant below has applied to become a Medicaid Waiver Provider. Your cooperation in completing this reference will greatly assist the Agency for Persons with Disabilities (APD) in determining if the applicant meets the minimum qualifications to become a Waiver Provider.

INSTRUCTIONS:

- Please type or print legibly.
- Applicants must have references from **two (2) supervisors or co-workers** who are familiar with their work in a Developmental Disability setting.
- **APPLICANT** – Complete Part I, provide this form to your references with a return self-addressed envelope. Provide the completed form from your reference with your application materials.
- **REFERENCE** – Complete Part II and return this form to the applicant in the envelope provided to you.

PART I – APPLICANT

Name:

PART II - REFERENCE

REFERENCE NAME:

ADDRESS:

STREET	CITY	STATE	ZIP
--------	------	-------	-----

PHONE:

OTHER CONTACT INFORMATION:

RELATIONSHIP TO APPLICANT: SUPERVISOR CO-WORKER

DATES OF RELATIONSHIP: FROM: _____ TO: _____
MM/DD/YY

PROFESSIONAL POSITION WHEN WORKING WITH APPLICANT:

Title:

Agency/Institution:

Address:

RECOMMENDATION:

I Recommend Do Not Recommend the Applicant for Enrollment

ADDITIONAL COMMENTS:

[Please write any comments that would assist the APD Enrollment Liaison in making a decision on this Applicant for enrollment.]

Reference Signature

Date

PROVIDER APPLICANT REFERENCE FORM

The applicant below has applied to become a Medicaid Waiver Provider. Your cooperation in completing this reference will greatly assist the Agency for Persons with Disabilities (APD) in determining if the applicant meets the minimum qualifications to become a Waiver Provider.

INSTRUCTIONS:

- Please type or print legibly.
- Applicants must have references from **two (2) supervisors or co-workers** who are familiar with their work in a Developmental Disability setting.
- **APPLICANT** – Complete Part I, provide this form to your references with a return self-addressed envelope. Provide the completed form from your reference with your application materials.
- **REFERENCE** – Complete Part II and return this form to the applicant in the envelope provided to you.

PART I – APPLICANT

Name:

PART II - REFERENCE

REFERENCE NAME:

ADDRESS:

STREET	CITY	STATE	ZIP
--------	------	-------	-----

PHONE:

OTHER CONTACT INFORMATION:

RELATIONSHIP TO APPLICANT: SUPERVISOR CO-WORKER

DATES OF RELATIONSHIP: FROM: _____ TO: _____
MM/DD/YY

PROFESSIONAL POSITION WHEN WORKING WITH APPLICANT:

Title:

Agency/Institution:

Address:

RECOMMENDATION:

I Recommend Do Not Recommend the Applicant for Enrollment

ADDITIONAL COMMENTS:

[Please write any comments that would assist the APD Enrollment Liaison in making a decision on this Applicant for enrollment.]

Reference Signature

Date

EVAN HOME CARE LLC

JOB DESCRIPTION / PERFORMANCE EVALUATION

POSITION: Home Health Aide (HHA) / Certified Nursing Assistant (CNA)

SUPERVISOR: Agency Owner

STATUS: Employee

POSITION GOAL: To provide personal services to recipients of Agency for Persons with Disabilities (APD) iBudget Waiver program in a manner that reflects the Agency's person-centered philosophy and standards, and in accordance with all state regulations. The HHA/CNA will perform specified, nonclinical, personal services as outlined in the recipient's Implementation Plan.

Essential Functions / Evaluation:	Sat	Unsat
Provide service to the recipient in accordance with recipient's Implementation Plan		
Assist recipient with:		
<ul style="list-style-type: none"> • Ambulation, eating, dressing, shaving, physical transfer • Grooming, including bed, sponge, tub, or shower bath • Shampoo: sink, tub, or bed • Nail (filing, buffing only) and skin care (applying lotion only) • Oral hygiene • Planning, preparing and serving meals, according to the Service Plan 		
Maintain a neat, clean, safe and healthy environment that includes light cleaning and straightening of the bathroom, straightening of the sleeping and living areas, washing the dishes and laundry, and other tasks to maintain cleanliness		
Be able to recognize an emergency situation and follow-up with assistance such as CPR and calling 911		
Provide physical and emotional support and maintain respect for the recipient, the recipient's privacy and property		
Observe appearance and gross behavioral changes in the recipient and report to the registered nurse		
Turn in visit notes to the Agency office per policy		
Provide service in a professional manner at all times and in all situations		
Communicate with Agency about any employment problems or concerns		
Be mature and able to deal effectively with the demands of the job		
Comply with in-service training requirements		
Communication skills, including speaking, reading and writing legibly in English		
Observe, report and document recipient status and the services provided		
Comply with infection control regulations and aseptic techniques		
Comply with all federal and state rules, regulations, and laws		
Comply with all Agency policies and procedures		
Other duties and special projects as assigned		

EVAN HOME CARE LLC

JOB DESCRIPTION / PERFORMANCE EVALUATION

Activities that the HHA/CNA **SHALL NOT** perform include:

- Assist recipient with self-administration of medications
- Changing of sterile dressing
- Irrigation of body cavities such as giving an enema
- Irrigation of colostomy
- Irrigation of a wound
- Perform a gastric irrigation or enteral feeding
- Catheterize a recipient
- Administer medication
- Apply heat by any method
- Care for a tracheotomy tube
- Assist with or change of colostomy bag and reinforcement of dressing
- Assisting with prescribed ice cap or collar
- Assisting with prescribed range of motion exercises
- Doing simple urine tests for sugar, acetone or albumin
- Any other services not included in the Implementation Plan

Supervisory Responsibilities: None

Qualifications, Education, Training and Skills:

- Clear a Level 2 Criminal Background screening through AHCA
- Education:
 - HHA diploma from a vocational school accredited by the Florida Department of Education or CNA Certification from the State of Florida;
 - Six months' experience as an HHA or CNA;
 - Signed APD Affidavit of Good Moral Character (Form A);
 - Evidence of current CPR certification; training may not have been received online;
 - Evidence of current professional liability insurance;
 - Evidence of having completed training as follows:
 - Direct Care Core Competencies (DCCC)*, which includes:
 - Basic Person-centered Planning
 - Introduction to Developmental Disabilities
 - Maintaining Health and Safety
 - Individual Choices, Rights and Responsibilities
 - Roles and Responsibilities of Direct Support Professionals (currently a section within Introduction to Developmental Disabilities)
 - Zero Tolerance, which includes:
 - Defining Abuse, Neglect and Exploitation
 - Recognizing the signs and symptoms of abuse, neglect and exploitation
 - Reporting to the Abuse Hotline
 - Prevention and Safety Planning
 - Overview of APD Waiver Provider Requirements*, which includes:
 - Overview of Medicaid Waivers
 - Overview of current APD Waiver
 - Provider Qualification and Enrollment (under current waiver)

EVAN HOME CARE LLC

JOB DESCRIPTION / PERFORMANCE EVALUATION

- Services Coverage and Limitations (under current waiver)
- Other relevant information provided in current handbooks
- APD Regional and field office liaisons for specific types of providers
- Incident Reporting
- AIDS/HIV/Infection Control*
- First Aid*
- CPR
- HIPAA*

Evidence of training marked with an asterisk (*) can be provided within 30 days of employment.

Fiscal Responsibility: None

Extent of Public Contact: Limited to direct contact with APD recipient

Physical Demands: Visual and auditory ability sufficient to comprehend English written/verbal communication.

Ability to perform tasks involving physical activities, which may include moderate to heavy assistance in transferring of recipients from seats, beds baths and commodes as well as bending and standing for the duration of the task. Occasional manipulation of recipients and equipment.

Work Conditions and Environment: Primarily in the APD recipient's home, not office based. The potential exists for occasional exposure to pathogens, blood and body fluids, infectious diseases, and toxic substances.

By signing below, I acknowledge that I have received a job description outlining the functions of my position. I agree to perform these functions within the Agency's established guidelines and direct any questions I may have about my job functions to my supervisor, the Assistant Administrator or the Administrator.

By my signature, I acknowledge and accept the title, authority and responsibilities of this position. I am qualified as set out above to carry out these duties.

Staff member Signature:	Supervisor Signature:
Print name:	Print name:
Date:	Date:

EVAN HOME CARE LLC DOCUMENTATION STANDARDS

All staff members of Evan Home Care LLC, (the Agency), will observe the following documentation guidelines:

- Every page in the record shall be identifiable to a specific recipient and bear the recipient's name and other Agency identifiable information, such as date of birth, etc.
- All recipient record documentation shall only be made on Agency-approved forms and documents.
- Every entry in the recipient record must include a complete date (month, day and four-digit year) and a time associated with it.
- Entries should be made as soon as possible after an event or observation is made. It is unacceptable for any Agency staff member to document in advance or to back-date an entry.
- Entries must be authenticated by a signature. At a minimum the signature should include the first initial, last name and title/credential.
- Documentation must be authenticated by the staff member who wrote it. A staff member shall never make an entry to a recipient record or sign documentation of service that has been written by someone else.
- Entries must be made in black pen, in permanent ink. No erasable pen, water-soluble ink or pencil may be used.
- Agency staff member notes shall be original documents and not photocopies.
- Documentation must be specific and based on facts and observation (i.e., things that are seen, heard, touched, smelled, signs, symptoms) and not in language that is vague or generalized. Examples of vague documentation: "*Recipient is doing well*" or "*Recipient isn't herself today.*" Preferred documentation: "*Recipient is alert and oriented to time and place,*" or "*Recipient exhibits anxious behavior such as pacing for an hour at a time in the early evening, and is agitated and asking about her daughter.*"
- Documentation must include all facts and pertinent information related to an event, services provided, recipient condition, response to services or information, etc.
- Documentation shall not contain abbreviations that are not generally accepted.

EVAN HOME CARE LLC DOCUMENTATION STANDARDS

- If the documentation is not legible by someone other than the author, it must be rewritten by the author on the next available line, by defining what the entry is, referring back to the original documentation and legibly rewriting the entry. *Example: "Clarified entry of (date)" and rewrite entry, date and sign. The rewritten documentation must be the same as the original.*
- Standardized forms may contain questions or fields that do not pertain to a recipient. In those cases, the Agency staff member will indicate that the item is not applicable by writing “N/A” to show that the question was reviewed and answered. All fields should have some entry whether they apply to the recipient or not. Blank fields may be subject to tampering or falsification by others.
- When an error is made in a recipient record entry or document, proper error correction procedures must be followed:
 - Draw line through information (thin pen line). Make sure that the inaccurate information is still legible.
 - Initial and date the corrected entry.
 - State the reason for the error (i.e. in the margin or above the note where possible).
 - Document the correct information. If the error is in a narrative note, it may be necessary to enter the correct information on the next available line/space documenting the current date and time and referring back to the incorrect entry.
- Agency staff members may never obliterate or otherwise alter the original entry by blacking out with marker, using white out, writing over an entry, etc.

I agree to uphold the Agency's Code of Conduct.

Staff member's name: (PRINT)	Signature:	Date:
------------------------------	------------	-------

EVAN HOME CARE LLC

CODE OF CONDUCT

Form C1

As a staff member of Evan Home Care LLC, (the Agency), I agree that I will:

- Hold paramount the safety, health and welfare of the Agency service recipients in the performance of my professional duties.
- Treat with respect and consideration all persons, regardless of race, religion, gender, sexual orientation, maternity, marital or family status, disability, age or national origin.
- Engage in carrying out the Agency's Mission in a professional manner.
- Demonstrate the highest standards of personal integrity and honesty in all activities.
- Avoid any interest or activity that is in conflict with the conduct of my obligations to the Agency and the Agency's recipients.
- Respect and protect privileged and confidential information of the Agency and its recipients.
- Report any fraud, abuse neglect or other illegal or immoral behavior which would harm or injure any Agency recipient, staff member or the Agency.
- Refrain from unethical, illegal or immoral behavior which would harm or injure any Agency recipient, staff member or the Agency.

I also understand that I may not:

- Use, for marketing or solicitation purposes, information from any source that identifies recipients receiving waiver services;
- Solicit recipients to request services directly or through an agent, through the use of fraud, intimidation, undue influence or any form of overreaching;
- Unduly influence a recipient to request a service, select a service Agency, or participate in an activity regardless of whether the recipient's request results in selection to the Agency;
- Compensate a recipient with funds or any item of value for the purposes of inducing the recipient to select the Agency for services or for any matter related to the provision of services.
- Receive any financial benefit as a result of being named the beneficiary of a life insurance policy covering a recipient served by the Agency.
- Benefit financially by borrowing or otherwise using the personal funds of a recipient served by the Agency.

I agree to uphold the Agency's Code of Conduct.

Staff member's name: (PRINT)	Signature:	Date:
------------------------------	------------	-------

EVAN HOME CARE LLC
ORIENTATION CHECKLIST

Form U

Staff member's Name: _____ Date: _____

By signing below, I acknowledge that I have been oriented on the following:

Covered	Topic
<input type="checkbox"/>	Person-centered philosophy of care, Code of Conduct (Form C1)
<input type="checkbox"/>	Provision of services & chain of command
<input type="checkbox"/>	Visit notes, Documentation Standards (Form D1), documentation guidelines & deadlines
<input type="checkbox"/>	Confidentiality & security of recipient information
<input type="checkbox"/>	Incidents, grievances & events requiring notification
<input type="checkbox"/>	Scope of services
<input type="checkbox"/>	Emergency measures
<input type="checkbox"/>	Other:

Confidentiality Policy and Agreement - I agree to:

- Maintain recipient confidentiality according to HIPAA standards and all other healthcare privacy legislation, even after my contract with Evan Home Care LLC is terminated.
- Refrain from discussing any recipient's information or the organization's business with anyone who does not work with or for Evan Home Care LLC, and who does not have a need to know about the information or business. I will refer any individuals making such inquiries to the Supervisor.
- Maintain the confidentiality of trade secrets, confidential or proprietary information regarding the organization's APD recipients or business.

Staff member's signature:	Date:
Orientation conducted by:	Date:

EVAN HOME CARE LLC

INDEPENDENT CONTRACTOR AGREEMENT

This Independent Contractor Agreement ("Agreement") is made and is effective this _____ of _____, 20_____, by and between _____ ("Contractor") and **Evan Home Care LLC**, the ("Agency"). Now, therefore, Contractor and Agency agree as follows:

1. Engagement and Services.

Agency hereby offers to Contractor, and Contractor accepts engagement to provide services to Agency for Persons with Disabilities (APD) recipients assigned to and by the Agency, said services being stipulated in the Independent Contractor Guidelines, attached hereto as if fully set out herein, and in compliance with and according to all standards of practice, laws and rules.

2. Place of Provision of Services.

Contractor agrees to render services primarily at the residences of Agency's APD recipients.

3. Schedule of Provision of Services.

Contractor agrees to provide services to Agency's APD recipients, as specifically assigned and authorized by Agency, in a safe and effective manner according to the schedule developed based on the recipient's needs as set out in the recipient's Recipient Assessment and Support Plan and as provided by the Agency.

4. Licenses.

The Agency will only hire people who have a professional license or certification or High School diploma or GED, and have at least one year of verifiable experience working directly with individuals receiving services in a medical, psychiatric, nursing, or childcare setting or working with recipients who have a developmental disability. The contractor is responsible for ensuring that his own license or certification remains current and valid during the contract period. Failure to maintain a valid license or certification status will cause suspension of assignments and may be grounds for termination of this Agreement with the Agency. The Contractor understands and acknowledges that he or she is responsible for meeting all educational requirements and all other requirements to maintain such license or certification.

5. Driving Requirements.

All contractors must have a valid picture identification card. Contractors who provide services such as driving the recipient to appointments using their own vehicles must have a valid Florida driver's license, reliable transportation to and from the assigned workplace and evidence of current auto insurance and vehicle registration. A contractor will not provide driving services until proof of the above is provided.

6. Background Screening.

The Contractor agrees that as a condition of this Agreement that he/she must clear a Level 2 criminal background screening by the Agency through the Agency for Health Care Administration. Contractor agrees to bear any cost associated with any background screening.

7. Criminal Arrests.

The Contractor agrees to inform the Agency, as soon as practicable, of contractor's arrest by any law enforcement agency and prior to providing care to any Agency recipient after such arrest. Contractor agrees that he/she will not provide care to Agency recipients if contractor has been arrested by any law enforcement agency, without prior approval by Agency.

8. Transportation

Contractor agrees to provide and maintain his or her own transportation.

9. Confidentiality.

Contractor shall maintain and preserve the confidentiality of all recipient health-related information in accordance with all State and Federal privacy laws and Agency policy.

10. Provision of Services.

Contractor agrees to abide by Agency's policies and procedures, including the Independent Contractor Guidelines, and to provide care or services to Agency's APD recipients according to: the Recipient Assessment and Support Plan, all standards of practice and professionalism all laws and rules.

11. Recipient Visit Notes.

Contractor shall be responsible for creating, updating, maintaining and submitting to the Agency the Daily Service Log, Daily Attendance Log & Progress Note and Monthly Summary for each recipient to whom he or she provides services. Contractor will assist the supervisor in preparing the Annual Recipient Progress Report upon request from Supervisor.

For each recipient to whom Contractor is providing services, Contractor shall submit all documentation referenced above to the supervisor by 5:00 p.m. each Monday for all service visits made from the previous Monday through Sunday.

Contractor's documentation will conform to the Agency's guidelines as stated in the document entitled "Documentation Standards;" this document is made a part of this Agreement as if fully set out herein.

12. Term, Renewal and Termination.

- A. This Agreement shall begin at the time both parties' signatures are affixed hereto and shall terminate one year thereafter, if not sooner by other terms herein, and may be renewed thereafter, from year to year, upon terms agreed to by the parties at that time.
- B. This Agreement may be terminated by either party at any time by written notice.

13. Independent Contractor.

Contractor is, and for all aspects concerning this Agreement shall be, a Contractor and not an employee, partner or agent of Agency. Contractor shall not be entitled to nor receive any benefit normally provided to Agency's employees such as, but not limited to, workers' compensation insurance, vacation payment, retirement, health care or sick pay. Agency shall not be responsible for withholding income or other taxes from the payments made to Contractor. Contractor shall be solely responsible for filing all returns and paying any income, social security or other tax levied upon or determined with respect to the payments made to Contractor pursuant to this Agreement.

14. Recipient Assessment and Support Plan.

Home Health Aides and Certified Nursing Assistants agree to provide services to Agency's APD recipients according to the Recipient Assessment and Support Plan, if they are assigned tasks therein.

15. Tools and Supplies.

Unless otherwise agreed to by the Agency in advance, Contractor shall be solely responsible for procuring, paying for and maintaining any supplies and equipment necessary or appropriate for the performance of Contractor's services hereunder.

16. Controlling Law and Venue.

This Agreement shall be governed by and construed in accordance with the laws of the State of Florida. Any action to enforce or construe any element of this Agreement shall be conducted in Osceola County, Florida.

17. Headings.

The headings in this Agreement are inserted for convenience only and shall not be used to define, limit or describe the scope of this Agreement or any of the obligations herein.

18. Independent Contractor Guidelines.

Contractor agrees to abide by all of the terms and conditions as set out in the "Independent Contractor Guidelines" document, and the "Independent Contractor Guidelines" is made a part of this Agreement as if fully set out herein. Any modification to the terms of this agreement shall be in writing and signed by both parties hereto.

19. Severability.

If any term of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, then this Agreement, including all of the remaining terms, will remain in full force and effect as if such invalid or unenforceable term had never been included.

20. Code of Conduct.

Contractor agrees to uphold the principles in the Agency's Code of Conduct; this document is made a part of this Agreement as if fully set out herein.

21. Maintenance of Documents.

The Agency shall maintain possession of this document, with access for copying provided to the Contractor at reasonable times. The Contractor shall obtain a copy of this Agreement upon the signing hereof by both parties.

22. Payment for Services.

Payment for services provided by Contractor under this agreement is calculated from Monday through Sunday, each week. Payment will be by check or direct deposit. Payment shall be made bi-weekly. Contractor shall bear all of Contractor's expenses incurred in the performance of this Agreement. Payment shall be in the amount per hour as set out in the Addendum, below. Billable time documentation must be submitted by 10:00 a.m. on each Monday.

23. Hold Harmless.

Contractor hereby indemnifies and holds harmless the Agency, any of its officers; any hospital, facility, physician, or any referring source and/or any clients referred by Agency against any liability that might arise. Contractor further agrees to hold harmless and defend Agency from and against any and all claims instituted against Agency, and hereby indemnifies Agency from and against any and all claims, costs, damages, expenses, liabilities and losses which Agency may suffer and which arise out of or which are related to claims in any manner whatsoever, including all costs and attorney's

fees which Agency may incur as a result of Contractor services rendered to any recipient referred by Agency to Contractor whether said claim is covered by insurance or not.

24. Release of Information.

Contractor authorizes and directs the Agency to permit access to and release to, and permit the copying and removal of information from Contractor records and writings (including records and writings from other facilities, Agencies, and physicians) regarding Contractor to any person, agency, or facility and to any person or agency involved in licensing, auditing, certifying, accrediting, or otherwise evaluating or approving Agency. Agency may computerize or otherwise incorporate information regarding Contractor in a data processing or like system.

25. Final Agreement & Notice.

This Agreement constitutes the final understanding and Agreement between the parties with respect to the subject matter hereof and supersedes all prior negotiations, understandings and agreements between the parties, whether written or oral. This Agreement may be amended, supplemented or changed only by an agreement, either hereon with both parties' initials, or separately in writing signed by both of the parties. Any notice given under this Agreement shall be sufficient if it is in writing and if sent by certified or registered mail.

IN WITNESS WHEREOF, this Agreement has been executed by the parties as of the date latest date below.

Contractor:

By: _____

Print Name: _____

Date: _____

The Agency:

By: _____

_____, Administrator

(Print Name)

Date: _____

RENEWAL

IN WITNESS WHEREOF, this Agreement has been renewed by the parties as of the date latest date below.

Contractor:

By: _____

Print Name: _____

Date: _____

The Agency:

By: _____

_____, Administrator

(Print Name)

Date: _____

Addendum A
Payment Schedule

\$_____ per hour;

Initials:_____ ; Date _____

Administrator Initials:_____ ; Date _____

\$_____ per hour;

Initials:_____ ; Date _____

Administrator Initials:_____ ; Date _____

\$_____ per hour;

Initials:_____ ; Date _____

Administrator Initials:_____ ; Date _____

\$_____ per hour;

Initials:_____ ; Date _____

Administrator Initials:_____ ; Date _____

ATTESTATION OF GOOD MORAL CHARACTER

Employee/Applicant/Contractor/Volunteer Name:

By signing this form, I affirm and attest that I meet the Moral Character requirements for employment as required pursuant to Chapter 435, Florida Statutes, and Section 393.0655, Florida Statutes.

Provider/Employer Name:

I have not been arrested with disposition pending or found guilty of regardless of adjudication, or entered a plea of nolo contendre (no contest) to or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction for any of the offenses listed below.

Criminal Offenses listed in section 435.04, F.S.

- (a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
- (b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
- (c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
- (d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- (e) Section 782.04, relating to murder.
- (f) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.
- (g) Section 782.071, relating to vehicular homicide.
- (h) Section 782.09, relating to killing of an unborn quick child by injury to the mother.
- (i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.
- (j) Section 784.011, relating to assault, if the victim of the offense was a minor.
- (k) Section 784.03, relating to battery, if the victim of the offense was a minor.
- (l) Section 787.01, relating to kidnapping.
- (m) Section 787.02, relating to false imprisonment.
- (n) Section 787.025, relating to luring or enticing a child.
- (o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.
- (p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.
- (q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.
- (r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.
- (s) Section 794.011, relating to sexual battery.
- (t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.
- (u) Section 794.05, relating to unlawful sexual activity with certain minors.
- (v) Chapter 796, relating to prostitution.
- (w) Section 798.02, relating to lewd and lascivious behavior.
- (x) Chapter 800, relating to lewdness and indecent exposure.
- (y) Section 806.01, relating to arson.
- (z) Section 810.02, relating to burglary.

- (aa) Section 810.14, relating to voyeurism, if the offense is a felony.
 - (bb) Section 810.145, relating to video voyeurism, if the offense is a felony.
 - (cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.
 - (dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.
 - (ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.
 - (ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.
 - (gg) Section 825.103, relating to felony offenses for the exploitation of an elderly person or disabled adult.
 - (hh) Section 826.04, relating to incest.
 - (ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.
 - (jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.
 - (kk) Former s. 827.05, relating to negligent treatment of children.
 - (ll) Section 827.071, relating to sexual performance by a child.
 - (mm) Section 843.01, relating to resisting arrest with violence.
 - (nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.
- (oo) Section 843.12, relating to aiding in an escape.
 - (pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institution.
 - (qq) Chapter 847, relating to obscene literature.
 - (rr) Section 874.05, relating to encouraging or recruiting another to join a criminal gang.
 - (ss) Chapter 893, relating to drug abuse prevention and control if the offense was a felony or if any other person involved in the offense was a minor.
 - (tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting requirements for such sexual misconduct.
 - (uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.
 - (vv) Section 944.40, relating to escape.
 - (ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.
 - (xx) Section 944.47, relating to introduction of contraband into a state correctional facility.
 - (yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.
 - (zz) Section 985.711, relating to contraband introduced into detention facilities

435.04(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Section 393.0674(2), felony offenses for the release or use of information from juvenile records of the Agency for Persons with Disabilities for any purpose other than screening for employment

Criminal Offenses listed in section 393.0655 (5), F.S.

- (a) Any authorizing statutes, if the offense was a felony.
- (b) This chapter, if the offense was a felony.
- (c) Section 409.920, relating to Medicaid provider fraud.
- (d) Section 409.9201, relating to Medicaid fraud.
- (e) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
- (f) Section 817.234, relating to false and fraudulent insurance claims.
- (g) Section 817.505, relating to patient brokering.
- (h) Section 817.568, relating to criminal use of personal identification information.
- (i) Section 817.60, relating to obtaining a credit card through fraudulent means.
- (j) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
- (k) Section 831.01, relating to forgery.
- (l) Section 831.02, relating to uttering forged instruments.
- (m) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
- (n) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

The following acknowledgements apply to all Direct Service Providers and/or Employees, Contract Providers, and Volunteers. Please initial each statement.

- _____ I affirm that I have not been designated as a sexual predator pursuant to s. 775.21; a career offender pursuant to s. 775.261; or a sexual offender pursuant to s. 943.0435, unless the requirement to register as a sexual offender has been removed pursuant to s. 943.04354.
- _____ I understand that I must acknowledge the existence of any applicable criminal record relating to the above lists of offenses including those under any similar statute of another jurisdiction, regardless of whether or not those records have been sealed or expunged.
- _____ I understand that, while employed or volunteering in any position that requires an APD background screening as a condition of employment, I must immediately notify my supervisor/employer of any arrest, any notice of possible criminal prosecution including any violation or infraction mandating a court appearance. Reporting must be done immediately if during normal working hours or immediately the next business day if after normal working hours.

ONE OF THE FOLLOWING STATEMENTS MUST BE SIGNED:

I attest that I have read the above carefully and state that my attestation here is true and correct and that my record **does not contain any of the above listed offenses.** I understand, under penalty of perjury, all employees in such positions of trust or responsibility shall attest to meeting the requirements to the background screening standards set forth in Chapter 435 and Section 393.0655.

Signature of Affiant

Date

OR

My record **contains one or more of the applicable disqualifying** acts or offenses listed above.

Signature of Affiant

Date

Note: If you have previously been granted an APD exemption for this disqualifying offense, a copy of the APD exemption letter must be attached.

OR

I am a licensed physician, licensed nurse, or other professional licensed and regulated by the Department of Health. I will be **holding a position that is within the scope of my licensed practice,** and I am not subject to the screening provisions of section 393.0655, Florida Statutes.

Signature of Affiant

Date

Position for Provider/Employer listed on pg. 1



PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

Employee/Contractor Name (Printed)

Employee/Contractor Signature

Date

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division



PRIVACY STATEMENT

Authority: The FBI's acquisition, preservation, and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L. 94-29; Pub.L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.



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 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td>-</td><td> </td><td> </td><td>-</td><td> </td><td> </td><td> </td></tr></table>				-			-				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):

- | |
|---|
| <input type="checkbox"/> 1. A citizen of the United States |
| <input type="checkbox"/> 2. A noncitizen national of the United States (See instructions) |
| <input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____ |
| <input type="checkbox"/> 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.

QR Code - Section 1
Do Not Write In This Space

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

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



Employer Completes Next Page





Employment Eligibility Verification

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

USCIS

Form I-9

OMB No. 1615-0041

Expires 10/31/2022

[Redacted]				
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
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)	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)	List C Employment Authorization
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) 10/21/2019	Title of Employer or Authorized Representative Owner	
Last Name of Employer or Authorized Representative Estevez	First Name of Employer or Authorized Representative Vadia	Employer's Business or Organization Name Evan Home Care, LLC	
Employer's Business or Organization Address (Street Number and Name) 1101 Miranda Ln	City or Town Kissimmee	State FL	ZIP Code 34741

A. New Name (if applicable)		B. Date of Birth (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
--	---------------------------	---

Request for Taxpayer Identification Number and Certification

► Go to www.irs.gov/FormW9 for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type.
See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.						
2 Business name/disregarded entity name, if different from above						
3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.						
<input type="checkbox"/> Individual/sole proprietor or single-member LLC		<input type="checkbox"/> C Corporation	<input type="checkbox"/> S Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Trust/estate	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.						
<input type="checkbox"/> Other (see instructions) ►						
5 Address (number, street, and apt. or suite no.) See instructions.				Requester's name and address (optional)		
6 City, state, and ZIP code						
7 List account number(s) here (optional)						

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number
_____ - _____ - _____

or
Employer identification number
_____ - _____ - _____

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification Instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here
Signature of
U.S. person ►

Date ►

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding, later.*