



1st Premier
Home Care, Inc

Job Description

Title: Personal Care Worker/ Homemaker
(Unskilled)
Non-Exempt

Reports to: Consumer

Date:

General Purpose of Position

Under direct supervision is responsible for assisting clients with the tasks of daily living related to personal care and to home management. The primary goals are promotion of consumer dignity, independence, comfort, mobility, personal appearance, and safety.

Primary Duties and Responsibilities

Approx. % of time:	Duty or Responsibility
65	Personal care of the client: <ul style="list-style-type: none">• Assist with bathing in tub, shower, or with sponge bath• Assist with grooming to include care of hair, shaving, and ordinary care of nails (limited to filing and cleaning)• Oral care• Skin care• Dressing/undressing• Assisting individual to move on/off bedpan, commode, or toilet (unskilled transfer)
15	Light housekeeping <ul style="list-style-type: none">• Floor care to include vacuuming, sweeping, and mopping• Dusting• Bathroom cleaning• Bed making and linen change• Laundry• Dishes

- Garbage and waste disposal

5	Meal Preparation
5	Documenting according to procedures all visits made and services provided to the consumer
3	Feeding (unskilled)
2	Transferring in/out of bed or to change position (unskilled)
2	Ambulation
2	Respite (relief of family members)
1	Medication reminder

Other Duties and Responsibilities

The consumer or his/her representative may make additional requests for services not described within this document. Such requests may be performed if on the care plan and if time allows during the visit. Must adhere to the policies and procedures of 1st. Should have the ability to respond appropriately in stressful situations.

Employees are held accountable for all duties of this job

Responsibility for Work of Others

No Supervisory responsibilities are associated with this position

Responsibility for Interpersonal Contacts

Attendants should be able to communicate effectively. The Attendant must maintain strict consumer confidentiality at all times.

Potential Impact of Work on the Organization

It is the responsibility of the attendants to adhere to the agency's policies and procedures to prevent any potential negative impacts in the future.

Position Qualifications: Education/Formal Training

- N/A

Licenses, Certificates, Registrations

- 1st will provide training and certification where applicable

Work Experience

- Experience in the field of home health care is preferred, but not required skills
- Must have ability to successfully complete quizzes given upon subject matters covered during orientation
- Must have ability to speak clearly and effectively in a variety of settings
- Must have ability to follow written and/or oral instructions
- Must have a record of reporting to work consistently and on time
- Must have own transportation to include valid driver's license, current auto insurance and reliable vehicle, or a workable plan alternate transportation.

Physical Demands

While performing the duties of this position, the employee will be required to perform tasks involving physical activity common to ordinary personal care and household chores. Assisting with homemaking should not exceed 15 lbs. There may be bending, and prolonged standing associated with this position. Must have own transportation to include valid drivers license, current auto insurance and reliable vehicle or a workable plan for alternate transportation.

Work Environment

Flexible work schedule to include days/nights, weekdays, and some required weekends. 1st does not schedule in shifts or guarantee hours.

This job description is not intended, and should not be construed, to be an exhaustive list of all responsibilities, qualifications, or working conditions associated with this position.

Printed Name _____

Employee Signature _____

Employee's Withholding Certificate

OMB No. 1545-0074

2021

▶ **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.**

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**
(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**
(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶ ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

Multiply the number of other dependents by \$500 ▶ \$ _____

Add the amounts above and enter the total here **3** \$ _____

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 **and** you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2021 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2022.

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

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

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

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

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

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

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



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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2021 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

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

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

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

- 1** Enter an estimate of your 2021 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
- 2** Enter: $\left\{ \begin{array}{l} \bullet \$25,100 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$18,800 \text{ if you're head of household} \\ \bullet \$12,550 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$190	\$850	\$890	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,100	\$1,870	\$1,870
\$10,000 - 19,999	190	1,190	1,890	2,090	2,220	2,220	2,220	2,220	2,300	3,300	4,070	4,070
\$20,000 - 29,999	850	1,890	2,750	2,950	3,080	3,080	3,080	3,160	4,160	5,160	5,930	5,930
\$30,000 - 39,999	890	2,090	2,950	3,150	3,280	3,280	3,360	4,360	5,360	6,360	7,130	7,130
\$40,000 - 49,999	1,020	2,220	3,080	3,280	3,410	3,490	4,490	5,490	6,490	7,490	8,260	8,260
\$50,000 - 59,999	1,020	2,220	3,080	3,280	3,490	4,490	5,490	6,490	7,490	8,490	9,260	9,260
\$60,000 - 69,999	1,020	2,220	3,080	3,360	4,490	5,490	6,490	7,490	8,490	9,490	10,260	10,260
\$70,000 - 79,999	1,020	2,220	3,160	4,360	5,490	6,490	7,490	8,490	9,490	10,490	11,260	11,260
\$80,000 - 99,999	1,020	3,150	5,010	6,210	7,340	8,340	9,340	10,340	11,340	12,340	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,930	7,130	8,260	9,320	10,520	11,720	12,920	14,120	15,090	15,290
\$150,000 - 239,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,230	16,190	16,400
\$240,000 - 259,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,270	17,040	18,040
\$260,000 - 279,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,870	14,870	16,870	18,640	19,640
\$280,000 - 299,999	2,040	4,440	6,500	7,900	9,230	10,470	12,470	14,470	16,470	18,470	20,240	21,240
\$300,000 - 319,999	2,040	4,440	6,500	7,940	10,070	12,070	14,070	16,070	18,070	20,070	21,840	22,840
\$320,000 - 364,999	2,720	5,920	8,780	10,980	13,110	15,110	17,110	19,110	21,190	23,490	25,560	26,860
\$365,000 - 524,999	2,970	6,470	9,630	12,130	14,560	16,860	19,160	21,460	23,760	26,060	28,130	29,430
\$525,000 and over	3,140	6,840	10,200	12,900	15,530	18,030	20,530	23,030	25,530	28,030	30,300	31,800

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$440	\$940	\$1,020	\$1,020	\$1,410	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040	\$2,040
\$10,000 - 19,999	940	1,540	1,620	2,020	3,020	3,470	3,470	3,470	3,640	3,840	3,840	3,840
\$20,000 - 29,999	1,020	1,620	2,100	3,100	4,100	4,550	4,550	4,720	4,920	5,120	5,120	5,120
\$30,000 - 39,999	1,020	2,020	3,100	4,100	5,100	5,550	5,720	5,920	6,120	6,320	6,320	6,320
\$40,000 - 59,999	1,870	3,470	4,550	5,550	6,690	7,340	7,540	7,740	7,940	8,140	8,150	8,150
\$60,000 - 79,999	1,870	3,470	4,690	5,890	7,090	7,740	7,940	8,140	8,340	8,540	9,190	9,990
\$80,000 - 99,999	2,000	3,810	5,090	6,290	7,490	8,140	8,340	8,540	9,390	10,390	11,190	11,990
\$100,000 - 124,999	2,040	3,840	5,120	6,320	7,520	8,360	9,360	10,360	11,360	12,360	13,410	14,510
\$125,000 - 149,999	2,040	3,840	5,120	6,910	8,910	10,360	11,360	12,450	13,750	15,050	16,160	17,260
\$150,000 - 174,999	2,220	4,830	6,910	8,910	10,910	12,600	13,900	15,200	16,500	17,800	18,910	20,010
\$175,000 - 199,999	2,720	5,320	7,490	9,790	12,090	13,850	15,150	16,450	17,750	19,050	20,150	21,250
\$200,000 - 249,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
\$250,000 - 399,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
\$400,000 - 449,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,910	21,220	22,520
\$450,000 and over	3,140	6,250	8,830	11,330	13,830	15,790	17,290	18,790	20,290	21,790	23,100	24,400

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$820	\$930	\$1,020	\$1,020	\$1,020	\$1,420	\$1,870	\$1,870	\$1,910	\$2,040	\$2,040
\$10,000 - 19,999	820	1,900	2,130	2,220	2,220	2,620	3,620	4,070	4,110	4,310	4,440	4,440
\$20,000 - 29,999	930	2,130	2,360	2,450	2,850	3,850	4,850	5,340	5,540	5,740	5,870	5,870
\$30,000 - 39,999	1,020	2,220	2,450	2,940	3,940	4,940	5,980	6,630	6,830	7,030	7,160	7,160
\$40,000 - 59,999	1,020	2,470	3,700	4,790	5,800	7,000	8,200	8,850	9,050	9,250	9,380	9,380
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,850	11,050	11,250	11,520	12,320
\$80,000 - 99,999	1,880	4,280	5,710	7,000	8,200	9,400	10,600	11,250	11,590	12,590	13,520	14,320
\$100,000 - 124,999	2,040	4,440	5,870	7,160	8,360	9,560	11,240	12,690	13,690	14,690	15,670	16,770
\$125,000 - 149,999	2,040	4,440	5,870	7,240	9,240	11,240	13,240	14,690	15,890	17,190	18,420	19,520
\$150,000 - 174,999	2,040	4,920	7,150	9,240	11,240	13,290	15,590	17,340	18,640	19,940	21,170	22,270
\$175,000 - 199,999	2,720	5,920	8,150	10,440	12,740	15,040	17,340	19,090	20,390	21,690	22,920	24,020
\$200,000 - 249,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
\$250,000 - 349,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
\$350,000 - 449,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,900	25,200
\$450,000 and over	3,140	6,840	9,570	12,160	14,660	17,160	19,660	21,610	23,110	24,610	26,050	27,350



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][][] - [][] - [][][][]		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>
<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. <i>(See instructions)</i> <i>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.</i> 1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____
QR Code - Section 1 Do Not Write In This Space

Signature of Employee	Today's Date (mm/dd/yyyy)
-----------------------	---------------------------

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
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		<div>Additional Information</div> <div>QR Code - Sections 2 & 3 Do Not Write In This Space</div>		
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				

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

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

Signature of Employer or Authorized Representative 	Today's Date(mm/dd/yyyy)	Title of Employer or Authorized Representative HR Director/Owner	
Last Name of Employer or Authorized Representative Quintanilla	First Name of Employer or Authorized Representative Richard	Employer's Business or Organization Name 5280 Home Care and Attendant Services Inc	
Employer's Business or Organization Address (Street Number and Name) 2600 S Parker Rd Suite 7-372	City or Town Aurora	State CO	ZIP Code 80014

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

**Employee - Annual Tuberculosis (TB)
Risk Assessment Questionnaire**



COLORADO
Department of Public
Health & Environment

Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Phone _____ Date of Birth _____ Country of Birth _____

1. Have you traveled outside the U.S. since your last risk assessment? ☐ No ☐ Yes

If yes, list countries and purpose of travel _____

2. Have you been diagnosed with a chronic condition that may impair your immune system?

☐ No ☐ Yes If yes, check all that apply

- | | | |
|--|--|--|
| <input type="checkbox"/> Chronic steroid use | <input type="checkbox"/> Gastrectomy/intestinal bypass | <input type="checkbox"/> Diabetes mellitus |
| <input type="checkbox"/> HIV infection | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Dialysis/Renal failure |
| <input type="checkbox"/> Cancer of the head or neck | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Chronic malabsorption syndromes |
| <input type="checkbox"/> Silicosis | <input type="checkbox"/> Use of TNF- α antagonist | <input type="checkbox"/> Low body weight (10% or more below ideal) |
| <input type="checkbox"/> Leukemia, lymphoma or Hodgkin's disease | <input type="checkbox"/> Other _____ | |

3. Have you ever resided, worked or volunteered in any of the following facilities?

☐ No ☐ Yes If yes, check all that apply

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Prison | <input type="checkbox"/> Hospital | <input type="checkbox"/> Nursing home |
| <input type="checkbox"/> Homeless shelter | <input type="checkbox"/> Other long term treatment center _____ | |

4. Do you currently have any of the following symptoms?

☐ No ☐ Yes If yes, check all that apply

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Cough \geq 3 weeks | <input type="checkbox"/> Unexplained fever | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Productive cough (coughing up something) | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Respiratory difficulty (shortness of breath) | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weakness |

5. Have you ever had contact with a person known to have active tuberculosis?

☐ No ☐ Yes

6. Have you ever had an abnormal chest x-ray?

☐ No ☐ yes

7. Have you had a tuberculin skin test or IGRA before?

☐ No ☐ Yes If yes, list where given _____ Date ____ / ____ / ____

If yes, provide documentation (attach results)

- a. If the test result was positive, did you take medications?

☐ No ☐ yes

- b. If you took medication(s), what did you take?

Name of medication: _____

[] Don't know

If yes, provide documentation (attach results)

**Employee - Annual Tuberculosis (TB)
Risk Assessment Questionnaire**



COLORADO
Department of Public
Health & Environment

- c. Where were you treated? _____
(city, state, country, doctor's contact information)
- d. In what year did you start treatment? _____
- e. How long did you take this medication? _____

The information above is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.

Employee signature

Date

For Internal Use Only (PRINT ONLY)

Name of Sender _____ Title _____

Facility Name _____

Phone Number _____ Secure Fax _____

Address _____ State _____ Zip _____

Sender Signature _____ Date Referral Sent _____

Referred to:

☐ PCP ☐ Urgent Care ☐ ED ☐ Employee Health ☐ Other

Name of person/facility _____

Address _____

☐ Fax _____ phone call _____

Reason for Referral _____

Requested Follow Up

☐ TST/PPD ☐ IGRA ☐ CXR ☐ CT ☐ Medical Evaluation ☐ 3 Sputum for Acid Fast Bacilli

☐ Other _____

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

OMB No. 1545-1500

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

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

Your name _____ Social security number ► _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

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

- 1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 2 ☐ Check here if **any** of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
 - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
 - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
 - I am at least age 18 but **not** age 40 or older and I am a member of a family that:
 - a. Received SNAP benefits (food stamps) for the past 6 months; **or**
 - b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
 - During the past year, I was convicted of a felony or released from prison for a felony.
 - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
 - I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.
- 3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.
- 5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months; **or**
 - Received TANF payments for any 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
 - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.
- 7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

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

Job applicant's signature ►

Date

For Employer's Use Only

Employer's name _____ Telephone no. _____ EIN ► _____

Street address _____

City or town, state, and ZIP code _____

Person to contact, if different from above _____ Telephone no. _____

Street address _____

City or town, state, and ZIP code _____

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

Date applicant:

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

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

Employer's signature ►

Title

Date

Privacy Act and Paperwork Reduction Act Notice

Section references are to the Internal Revenue Code.

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

criminal litigation, to the Department of Labor for oversight of the certifications performed by the SWA, and to cities, states, and the District of Columbia for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

Recordkeeping . . . 6 hr., 27 min.

Learning about the law or the form 24 min.

Preparing and sending this form to the SWA 31 min.

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

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

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



1st Premier Home Care, Inc

Dear Clients,

Here is some information regarding the Whistleblower Law:

About the Program

OSHA's Whistleblower Protection Program enforces the whistleblower provisions of more than twenty whistleblower statutes protecting employees who report violations of various workplace safety and health, airline, commercial motor carrier, consumer product, environmental, financial reform, food safety, health insurance reform, motor vehicle safety, nuclear, pipeline, public transportation agency, railroad, maritime, and securities laws. Rights afforded by these whistleblower protection laws include, but are not limited to, worker participation in safety and health activities, reporting a work-related injury, illness or fatality, or reporting a violation of the statutes herein.

Workplace Safety and Health

Section 11(c) of the OSH Act prohibits employers from discriminating against their employees for exercising their rights under the OSH Act. These rights include filing an OSHA complaint, participating in an inspection or talking to an inspector, seeking access to employer exposure and injury records, reporting an injury, and raising a safety or health complaint with the employer. If workers have been retaliated or discriminated against for exercising their rights, they must file a complaint with OSHA within 30 days of the alleged adverse action.

Since passage of the OSH Act in 1970, Congress has expanded OSHA's whistleblower authority to protect workers from discrimination under twenty-two federal laws. Complaints must be reported to OSHA within set timeframes following the discriminatory action, as prescribed by each law.

For more information on the Whistleblower Law you can go to this site:

<https://www.whistleblowers.gov/>

Employee's Withholding Certificate

OMB No. 1545-0074

2021

▶ **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.**

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**
 (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**
 (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶ ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

Multiply the number of other dependents by \$500 ▶ \$ _____

Add the amounts above and enter the total here **3** \$ _____

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 **and** you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2021 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2022.

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

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

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

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

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

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

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



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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2021 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

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

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

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

- 1** Enter an estimate of your 2021 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
- 2** Enter: $\left\{ \begin{array}{l} \bullet \$25,100 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$18,800 \text{ if you're head of household} \\ \bullet \$12,550 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$190	\$850	\$890	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,100	\$1,870	\$1,870
\$10,000 - 19,999	190	1,190	1,890	2,090	2,220	2,220	2,220	2,220	2,300	3,300	4,070	4,070
\$20,000 - 29,999	850	1,890	2,750	2,950	3,080	3,080	3,080	3,160	4,160	5,160	5,930	5,930
\$30,000 - 39,999	890	2,090	2,950	3,150	3,280	3,280	3,360	4,360	5,360	6,360	7,130	7,130
\$40,000 - 49,999	1,020	2,220	3,080	3,280	3,410	3,490	4,490	5,490	6,490	7,490	8,260	8,260
\$50,000 - 59,999	1,020	2,220	3,080	3,280	3,490	4,490	5,490	6,490	7,490	8,490	9,260	9,260
\$60,000 - 69,999	1,020	2,220	3,080	3,360	4,490	5,490	6,490	7,490	8,490	9,490	10,260	10,260
\$70,000 - 79,999	1,020	2,220	3,160	4,360	5,490	6,490	7,490	8,490	9,490	10,490	11,260	11,260
\$80,000 - 99,999	1,020	3,150	5,010	6,210	7,340	8,340	9,340	10,340	11,340	12,340	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,930	7,130	8,260	9,320	10,520	11,720	12,920	14,120	15,090	15,290
\$150,000 - 239,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,230	16,190	16,400
\$240,000 - 259,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,270	17,040	18,040
\$260,000 - 279,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,870	14,870	16,870	18,640	19,640
\$280,000 - 299,999	2,040	4,440	6,500	7,900	9,230	10,470	12,470	14,470	16,470	18,470	20,240	21,240
\$300,000 - 319,999	2,040	4,440	6,500	7,940	10,070	12,070	14,070	16,070	18,070	20,070	21,840	22,840
\$320,000 - 364,999	2,720	5,920	8,780	10,980	13,110	15,110	17,110	19,110	21,190	23,490	25,560	26,860
\$365,000 - 524,999	2,970	6,470	9,630	12,130	14,560	16,860	19,160	21,460	23,760	26,060	28,130	29,430
\$525,000 and over	3,140	6,840	10,200	12,900	15,530	18,030	20,530	23,030	25,530	28,030	30,300	31,800

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$440	\$940	\$1,020	\$1,020	\$1,410	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040	\$2,040
\$10,000 - 19,999	940	1,540	1,620	2,020	3,020	3,470	3,470	3,470	3,640	3,840	3,840	3,840
\$20,000 - 29,999	1,020	1,620	2,100	3,100	4,100	4,550	4,550	4,720	4,920	5,120	5,120	5,120
\$30,000 - 39,999	1,020	2,020	3,100	4,100	5,100	5,550	5,720	5,920	6,120	6,320	6,320	6,320
\$40,000 - 59,999	1,870	3,470	4,550	5,550	6,690	7,340	7,540	7,740	7,940	8,140	8,150	8,150
\$60,000 - 79,999	1,870	3,470	4,690	5,890	7,090	7,740	7,940	8,140	8,340	8,540	9,190	9,990
\$80,000 - 99,999	2,000	3,810	5,090	6,290	7,490	8,140	8,340	8,540	9,390	10,390	11,190	11,990
\$100,000 - 124,999	2,040	3,840	5,120	6,320	7,520	8,360	9,360	10,360	11,360	12,360	13,410	14,510
\$125,000 - 149,999	2,040	3,840	5,120	6,910	8,910	10,360	11,360	12,450	13,750	15,050	16,160	17,260
\$150,000 - 174,999	2,220	4,830	6,910	8,910	10,910	12,600	13,900	15,200	16,500	17,800	18,910	20,010
\$175,000 - 199,999	2,720	5,320	7,490	9,790	12,090	13,850	15,150	16,450	17,750	19,050	20,150	21,250
\$200,000 - 249,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
\$250,000 - 399,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
\$400,000 - 449,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,910	21,220	22,520
\$450,000 and over	3,140	6,250	8,830	11,330	13,830	15,790	17,290	18,790	20,290	21,790	23,100	24,400

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$820	\$930	\$1,020	\$1,020	\$1,020	\$1,420	\$1,870	\$1,870	\$1,910	\$2,040	\$2,040
\$10,000 - 19,999	820	1,900	2,130	2,220	2,220	2,620	3,620	4,070	4,110	4,310	4,440	4,440
\$20,000 - 29,999	930	2,130	2,360	2,450	2,850	3,850	4,850	5,340	5,540	5,740	5,870	5,870
\$30,000 - 39,999	1,020	2,220	2,450	2,940	3,940	4,940	5,980	6,630	6,830	7,030	7,160	7,160
\$40,000 - 59,999	1,020	2,470	3,700	4,790	5,800	7,000	8,200	8,850	9,050	9,250	9,380	9,380
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,850	11,050	11,250	11,520	12,320
\$80,000 - 99,999	1,880	4,280	5,710	7,000	8,200	9,400	10,600	11,250	11,590	12,590	13,520	14,320
\$100,000 - 124,999	2,040	4,440	5,870	7,160	8,360	9,560	11,240	12,690	13,690	14,690	15,670	16,770
\$125,000 - 149,999	2,040	4,440	5,870	7,240	9,240	11,240	13,240	14,690	15,890	17,190	18,420	19,520
\$150,000 - 174,999	2,040	4,920	7,150	9,240	11,240	13,290	15,590	17,340	18,640	19,940	21,170	22,270
\$175,000 - 199,999	2,720	5,920	8,150	10,440	12,740	15,040	17,340	19,090	20,390	21,690	22,920	24,020
\$200,000 - 249,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
\$250,000 - 349,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
\$350,000 - 449,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,900	25,200
\$450,000 and over	3,140	6,840	9,570	12,160	14,660	17,160	19,660	21,610	23,110	24,610	26,050	27,350



1st Premier
Home Care, Inc

CLIENT CONFIDENTIALITY

1. The Agency and agent acting on behalf of the Agency, in accordance with a written contract, must ensure the confidentiality of all client information contained in the clinical record and may not release client identifiable information to the public.
2. The Agency will comply with applicable HIPAA rules and regulations.
3. Agency manager will determine which employees have access to confidential information.
4. Staff will treat any information obtained from clients, caregivers, physicians and other sources in a confidential manner.
5. Types of information that are considered confidential include, but are not limited to, electronic, computerized information, telephone and cell phone communication, verbal and faxed information.
6. Discussions of information regarding clients will be limited to information essential to the provision of care and services to the client.
7. All requests for specific client information, other than that related to provision of services, are directed to the manager, who will determine whether and to whom information will be released.
8. When clients are mentioned in memos, minutes, QM reports, phone calls etc., they will be referred to by client ID numbers or initials.
9. If a client's information is to be published, the client will be identified by initials or a pseudonym unless he/she specified otherwise.
10. Discussion of client information in a public place is discouraged. If a public phone or client's home phone must be used, care is taken to assure privacy. Never discuss the care of one client with another.
11. All written client information is stored in the patient's medical record. Charts are not removed from the office unless a specific reason has been identified and approved.
12. Computer files and transmission files are password protected against unauthorized use, alteration, or damage.

13. Home care records will not be left in unattended areas in the office, e.g., the reception area. All home care records will be kept stored in locked file cabinets or in compliance officer's locked office that is locked by code and not given to cleaning staff to minimize the possibility of damage from fire and water. Records will be protected against unauthorized corruption, damage and/or intrusion.

1st Premier home Care, Inc

14. Personnel records will not be left in unattended areas in the office, e.g., the reception area. All personnel records will be kept stored in locked file cabinets or in compliance officer's locked office that is locked by code and not given to cleaning staff to minimize the possibility of damage from fire and water. Records will be protected against unauthorized corruption, damage and/or intrusion.

15. Persons who are not employees of the Agency may have access to office after normal business hours, e.g., cleaning service. However, all home care records will be maintained in locked file cabinets or in compliance officers locked office that is locked by code and not given to cleaning staff after normal business hours to

16. decrease the likelihood of accessibility by such persons.

Clients may access their record in accordance with HIPAA policies.

17. The Agency shall advise the client of the agency's policies and procedures regarding disclosure of clinical information and records.

18. All staff will be oriented regarding the Agency Client Confidentiality policy and procedure.

19. All agency employees, Governing Body and members must sign a confidentiality agreement.

Printed Name _____

Employee Signature _____

1st Premier Home Care
Employment Disclosure Notice

As part of our hiring background investigation, we may prepare an investigative consumer report. The investigative consumer report may consist of contacting all listed prior employers to verify your employment history. It may also include, but not limited to, credit information reports, criminal history reports, driving history records and Colorado adult protective services reports. Under the provisions of the Fair Credit Act (15 USC at 1681-1681u) as amended, before we can seek such reports, we must have your written permission to obtain the information. You have the right, upon written request, to complete and accurate disclosure of the nature and scope of the investigation. You are also entitled to a copy of your Rights Under the Fair Credit Reporting Act.

Printed Name: _____

Applicant Signature: _____

Date: _____



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Home Care, Inc

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19. All agency employees, Governing Body and members must sign a confidentiality agreement.

Printed Name _____

Employee Signature _____

Employee - Annual Tuberculosis (TB)
Risk Assessment Questionnaire



COLORADO
Department of Public
Health & Environment

Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Phone _____ Date of Birth _____ Country of Birth _____

1. Have you traveled outside the U.S. since your last risk assessment? ☐ No ☐ Yes

If yes, list countries and purpose of travel _____

2. Have you been diagnosed with a chronic condition that may impair your immune system?

☐ No ☐ Yes If yes, check all that apply

- | | | |
|--|--|--|
| <input type="checkbox"/> Chronic steroid use | <input type="checkbox"/> Gastrectomy/intestinal bypass | <input type="checkbox"/> Diabetes mellitus |
| <input type="checkbox"/> HIV infection | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Dialysis/Renal failure |
| <input type="checkbox"/> Cancer of the head or neck | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Chronic malabsorption syndromes |
| <input type="checkbox"/> Silicosis | <input type="checkbox"/> Use of TNF- α antagonist | <input type="checkbox"/> Low body weight (10% or more below ideal) |
| <input type="checkbox"/> Leukemia, lymphoma or Hodgkin's disease | <input type="checkbox"/> Other _____ | |

3. Have you ever resided, worked or volunteered in any of the following facilities?

☐ No ☐ Yes If yes, check all that apply

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Prison | <input type="checkbox"/> Hospital | <input type="checkbox"/> Nursing home |
| <input type="checkbox"/> Homeless shelter | <input type="checkbox"/> Other long term treatment center _____ | |

4. Do you currently have any of the following symptoms?

☐ No ☐ Yes If yes, check all that apply

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Cough \geq 3 weeks | <input type="checkbox"/> Unexplained fever | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Productive cough (coughing up something) | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Respiratory difficulty (shortness of breath) | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weakness |

5. Have you ever had contact with a person known to have active tuberculosis?

☐ No ☐ Yes

6. Have you ever had an abnormal chest x-ray?

☐ No ☐ yes

7. Have you had a tuberculin skin test or IGRA before?

☐ No ☐ Yes If yes, list where given _____ Date ____ / ____ / ____

If yes, provide documentation (attach results)

- a. If the test result was positive, did you take medications?

☐ No ☐ yes

- b. If you took medication(s), what did you take?

Name of medication: _____

[] Don't know

If yes, provide documentation (attach results)

**Employee - Annual Tuberculosis (TB)
Risk Assessment Questionnaire**



COLORADO
Department of Public
Health & Environment

- c. Where were you treated? _____
(city, state, country, doctor's contact information)
- d. In what year did you start treatment? _____
- e. How long did you take this medication? _____

The information above is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.

Employee signature

Date

For Internal Use Only (PRINT ONLY)

Name of Sender _____ Title _____

Facility Name _____

Phone Number _____ Secure Fax _____

Address _____ State _____ Zip _____

Sender Signature _____ Date Referral Sent _____

Referred to:

☐ PCP ☐ Urgent Care ☐ ED ☐ Employee Health ☐ Other

Name of person/facility _____

Address _____

☐ Fax _____ phone call _____

Reason for Referral _____

Requested Follow Up

☐ TST/PPD ☐ IGRA ☐ CXR ☐ CT ☐ Medical Evaluation ☐ 3 Sputum for Acid Fast Bacilli

☐ Other _____



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][][] - [][] - [][][][]		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen national of the United States (<i>See instructions</i>)
<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. (<i>See instructions</i>) <i>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.</i> 1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____
QR Code - Section 1 Do Not Write In This Space

Signature of Employee	Today's Date (mm/dd/yyyy)
-----------------------	---------------------------

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
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		<div>Additional Information</div> <div>QR Code - Sections 2 & 3 Do Not Write In This Space</div>		
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)				

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

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

Signature of Employer or Authorized Representative 	Today's Date(mm/dd/yyyy)	Title of Employer or Authorized Representative HR Director/Owner	
Last Name of Employer or Authorized Representative Quintanilla	First Name of Employer or Authorized Representative Richard	Employer's Business or Organization Name 5280 Home Care and Attendant Services Inc	
Employer's Business or Organization Address (Street Number and Name) 2600 S Parker Rd Suite 7-372	City or Town Aurora	State CO	ZIP Code 80014

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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



1st Premier Home Care, Inc

Dear Clients,

Here is some information regarding the Whistleblower Law:

About the Program

OSHA's Whistleblower Protection Program enforces the whistleblower provisions of more than twenty whistleblower statutes protecting employees who report violations of various workplace safety and health, airline, commercial motor carrier, consumer product, environmental, financial reform, food safety, health insurance reform, motor vehicle safety, nuclear, pipeline, public transportation agency, railroad, maritime, and securities laws. Rights afforded by these whistleblower protection laws include, but are not limited to, worker participation in safety and health activities, reporting a work-related injury, illness or fatality, or reporting a violation of the statutes herein.

Workplace Safety and Health

Section 11(c) of the OSH Act prohibits employers from discriminating against their employees for exercising their rights under the OSH Act. These rights include filing an OSHA complaint, participating in an inspection or talking to an inspector, seeking access to employer exposure and injury records, reporting an injury, and raising a safety or health complaint with the employer. If workers have been retaliated or discriminated against for exercising their rights, they must file a complaint with OSHA within 30 days of the alleged adverse action.

Since passage of the OSH Act in 1970, Congress has expanded OSHA's whistleblower authority to protect workers from discrimination under twenty-two federal laws. Complaints must be reported to OSHA within set timeframes following the discriminatory action, as prescribed by each law.

For more information on the Whistleblower Law you can go to this site:

<https://www.whistleblowers.gov/>

1st Premier Home Care IHSS Orientation

What is IHSS –

- Participant directed service delivery option
- Available in the Elderly Blind and Disabled (EBD), Spinal Cord Injury (SCI), and Children's Home and Community Based Services (HCBS) Waivers
- Employer Authority

Client Responsibilities/Rights –

- Select Attendants
- Train Attendants
- Schedule Attendants
- Dismiss Attendants
- Directly schedule, Manager & Supervisor staff
- Notify agency of permanent schedule changes
- Determine the level of oversight

Characteristics of IHSS- -

- Allows Client to Select, Schedule and Manage Attendants –
- Peer Counseling –
- 24-hour Back-up Services Provided
- Nursing Staff Available to Provide Support
- Agency Manages Attendant Reimbursement –
- Clients may receive skilled care from Attendants without a CNA or nursing license because Nurse Practice Act and Nurse Aide Legislation are waived –
- If there is a need for skilled care, clients can choose to access IHSS HMA or Long-Term Home Health, depending on client preference
- Functional Skills Training

Limitations of IHSS –

- A family member cannot provide more than 40 hours of personal care or home maker tasks in one week (NEW)
- Health Maintenance is the only IHSS service offered on the HCBS Waiver –
- A family member shall not be reimbursed for providing only IHSS Homemaker Services
 - o A family member may perform homemaker tasks which are secondary and contiguous to IHSS Health Maintenance Activities. Additional service hours will not be authorized to complete homemaker tasks
 - o Family members are not eligible to be the client's IHSS homemaker
 - o Authorized Representatives cannot be providers

Role of IHSS Agency IHSS Agency Must:

- Provide 24-hour back up services

- Provide Attendant Basic Training or Skills Validation within 30 days after services begin
- Provide Intake and Orientation
- In consultation with the client, contact the client's physician and receive direction as to the appropriateness of continued care in the event of the observation of new symptoms or worsening condition (new)
- Collaborate with the client to determine the level of oversight

IHSS Agency Must Complete the IHSS Care Plan

- A statement of allowable attendant and personal care service hours
- A detailed listing of amount, scope and duration of each service to be provided for each day
- Documentation that adequate staffing including backup staff will be available to provide necessary services
- A dispute resolution process
- Level of oversight
- Who will be providing each service

IHSS Agency Must Offer and Document if the Following Supports were Accepted or Declined in IHSS Care Plan:

- Functional Skills Training –
- Assistance with Attendant selection
- Peer Counseling
- Independent living core services—As defined at 26-8.1-102 (3), C.R.S.

Caregiver Signature

Date

EMPLOYMENT APPLICATION



1st Premier
Home Care, Inc

INSTRUCTIONS: If you need help filling out this application form or for any phase of the employment process, please notify the person who gave you this form and every reasonable effort will be made to meet your needs in a reasonable amount of time.

- Please read "Applicant Note" below.
- Complete all pages of this application.
- Print clearly. Incomplete or illegible applications may not be accepted.
- If more space is needed to complete any question, use comments section on the back.
- Application will be valid for 60 days.

APPLICANT NOTE: This application form is intended for use in evaluating your qualifications for employment with us, an independently owned and operated 1st Premier Home Care. This is not an employment contract. Please answer all appropriate questions completely and accurately. False or misleading statements during the interview and on this form are grounds for terminating the application process or, if discovered after employment begins, terminating employment. All qualified applicants will receive consideration and will be treated throughout their employment without regard to race, color, religion, sex, national origin, age, disability, or any other protected class status under applicable law. Additional testing for the presence of illegal drugs in your body may be required prior to employment.

PERSONAL INFORMATION

Today's Date: _____

Positions(s) Applied For: _____

Name: _____
Last First Middle

Current Address: _____
Street City State Zip Code

Previous Address: _____
Street City State Zip Code

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Alternate Phone: (____) _____

Emergency Contact(s): _____ (____) _____
Name Phone

_____ (____) _____
Name Phone

Valid Driver's License #: _____ State Issued: _____ Exp. Date: _____

Make & Model of Vehicle: _____ Year of vehicle: _____

Auto In Co: _____ Policy # _____ Exp Date: _____

Have you ever submitted an application here before? **Yes / No** If yes, when? _____

Have you ever been employed here before? **Yes / No** If yes, when? _____

How did you hear about 1st Premier Home Care? _____

Have you have been given a copy of the job description for the position for which you have applied to review. **Yes / No**
Are you able to perform the essential functions of the job for which you are applying with or without a reasonable accommodation? **Yes / No**

Why are you interested in employment with us? _____

AVAILABILITY

Due to the nature of the business, no guarantee can be made as to the schedule or the amount of hours worked.

What date are you available to begin work? _____

Please complete all areas of availability:

_____ Mornings _____ Afternoon _____ Evenings _____ Overnights _____ Weekdays _____ Weekends

Please indicate the days of the week as well as the earliest and latest times that you are available for work.

		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Shift	From:							
	To:							

PREFERENCES

Please indicate the types of services which you are willing to provide:

<input type="checkbox"/>	Companionship	<input type="checkbox"/>	Housekeeping (dust/vacuum)	<input type="checkbox"/>	Errands/Shopping/Transportation*
<input type="checkbox"/>	Meal Preparation	<input type="checkbox"/>	Laundry/Ironing	<input type="checkbox"/>	Personal Care
<input type="checkbox"/>	Activities (games/crafts)	<input type="checkbox"/>	Medication Reminders	<input type="checkbox"/>	Dementia/Alzheimer's Care

**In order to be able to provide transportation or run errands, you will be required to have a valid driver's license and current auto insurance. A motor vehicle record check will be conducted and proof of insurance will be required.*

Are you willing to provide service to a client with a pet? Yes / No If yes, which ones: _____ Cats _____ Dogs

Are you willing to provide service to a client that smokes? Yes / No

JOB RELATED SKILLS

Describe any training or life skills you have that apply to caring for a senior:

Describe any work history you have that would apply to caring for a senior: _____

What do you like (or think you would like) most about working with older adults? _____

What do you like (or think you would like) least about working with older adults? _____

What personal rewards do you get from working with seniors? _____

EDUCATION *

Please circle highest grade completed:

Grade School: 6 7 8

High School: 9 10 11 12

College: 13 14 15 16 16+

School Type	School Name	City, State	Major/Subject	# Yrs Attended	Graduate
High School					Y / N
Vocational/Technical					Y / N
College/University					Y / N

*For employment our minimum education requirement is either a GED or High School diploma

WORK HISTORY

Your application will not be considered unless all questions in this section are answered. Since we will make every effort to contact previous employers, the correct telephone numbers of past employers are essential.

MOST RECENT EMPLOYER

Are you currently working for this employer? **Yes / No** If yes, may we contact? **Yes / No**

Company Name _____ City _____ State _____ (_____) _____
 Phone Number _____
 Dates Employed: From _____ to _____ Job Title _____ Supervisor's Name _____

Duties _____
 \$ _____ per _____
 Salary (Hour, Week, Month) _____ Reason for Leaving _____

SECOND MOST RECENT EMPLOYER

Company Name _____ City _____ State _____ (_____) _____
 Phone Number _____
 Dates Employed: From _____ to _____ Job Title _____ Supervisor's Name _____

Duties _____
 \$ _____ per _____
 Salary (Hour, Week, Month) _____ Reason for Leaving _____

THIRD MOST RECENT EMPLOYER

Company Name _____ City _____ State _____ (_____) _____
 Phone Number _____
 Dates Employed: From _____ to _____ Job Title _____ Supervisor's Name _____

Duties _____
 \$ _____ per _____
 Salary (Hour, Week, Month) _____ Reason for Leaving _____

SECURITY

*****Please be sure to complete the attached Authorization to do a criminal and motor vehicle background check.

1st Premier Home Care an independently owned and operated 1st Premier Home Care Inc.

As a condition of employment all employees must be "Bondable"& "Insurable". Are you at least 19 years of age? **Yes / No**

List states *and* counties of residence for the past seven years:

Have you had any moving traffic violations? **Yes / No** If yes, please describe: _____

Have you been charged/convicted of a felony and/or misdemeanor/or served time **Yes / No** If yes, please describe:

1) _____
2) _____

Have you ever been a charged perpetrator or appeared on any child abuse registry in the last 5 years? **Yes or No.**

REFERENCES (Do not include relatives)

Please complete all six references. Your application will not be considered unless six references are provided. Since we will contact these references, please notify them in advance. If we are unable to reach all 6 references, you will be asked to provide additional references.

Full Name	Phone Number	Best Time of Day to Call	Relationship	Number of Years Known
1)	H () W ()	AM / PM AM / PM		
2)	H () W ()	AM / PM AM / PM		
3)	H () W ()	AM / PM AM / PM		
4)	H () W ()	AM / PM AM / PM		
5)	H () W ()	AM / PM AM / PM		
6)	H () W ()	AM / PM AM / PM		

CERTIFICATION AND RELEASE: I certify that I have read and understand the applicant note on page one (1) of this form and that the answers given by me to the foregoing questions and the statements made by me are complete and true to the best of my knowledge and belief. I understand that any false information, omissions or misrepresentations of facts in this application may result in rejection of my application or discharge at any time during my employment. I authorize the company and/or its agents, including consumer-reporting bureaus, to verify any of this information including, but not limited to, criminal history and motor vehicle driving records. I authorize all persons, schools, companies and law enforcement authorities to release any information concerning my background and hereby release any said persons, schools, companies and law enforcement authorities from any liability for any damage whatsoever for issuing this information. I release this company from any liability which might result from making such investigations. I also understand that the use of illegal drugs is prohibited during employment. I am willing to submit to drug testing to detect the use of illegal drugs prior to and during employment. I understand that this application is not a contract of employment. My employment is contingent upon confirmation of credentials and successful completion of drug test or criminal background check. I also understand that if hired, regardless of any oral presentations to the contrary, the employment relationship between *Interim Management Inc.*, and myself is terminable at-will, so that both the company and I remain free to choose to end out work relationship at any time for any or no reason. Any changes in this employment relationship must be made in writing. My signature below acknowledges that I have read, understand, and agree to the above disclosure. I also understand that due to the nature of the business, no amount of work can be guaranteed.

APPLICANT SIGNATURE

DATE



1st Premier Home Care, Inc

1st Premier Home Care and Attendants Services 34 point cleaning checklist is here to assist our attendants. We specialize in the care of all our clients from skilled services to home care assistance. We as a team will only benefit from using this checklist to create a clean, comfortable, and safe home environment for our clients.

35 Point Cleaning Checklist:

Kitchen-

1. Countertops and backsplash cleaned (all items removed and then replaced)
2. Clean the outside of the appliances (oven, microwave, dishwasher, fridge, and stove)
3. Window sills cleaned
4. Small appliances wiped down (toaster, coffee maker, mixer, etc.)
5. Trash emptied
6. Dishes washed or dishwasher loaded (if it is a small load of dishes, wash them by hand, dry them and put them away)
7. Wash or dust tables and chairs
8. Floor swept and mopped (or vacuumed)
9. At least once a week, go through the refrigerator to make sure there are no spills, expired food/drinks, or food that is not stored properly. If there are, throw out the food and clean out the fridge.

Bathrooms-

1. Sink thoroughly cleaned, disinfected and rinsed
2. Tub and/or shower tiles thoroughly cleaned, disinfected and rinsed
3. Sink and tub/shower fixtures cleaned and shined
4. Mirrors cleaned (no streaks)
5. Window sills are cleaned
6. Vanity top cleaned (remove and replace items)
7. Towels changed if needed or requested
8. Trash emptied
9. Toilets cleaned and disinfected (inside and out)
10. Floor swept and mopped (or vacuumed)

Bedroom-

1. Linens changed if needed or requested
2. Beds made
3. All areas dusted-on top, in front and underneath (remove and replace items)
4. Picture frames dusted
5. Mirrors cleaned (no streaks)
6. Window sills are cleaned
7. Trash emptied
8. Baseboards dusted (if needed)
9. Light general straightening completed
10. Floor swept and mopped (or vacuumed)

Other Living Areas-including hallways and stairs-

1. All areas dusted-on top, on front, and underneath (all items removed and then replaced)
2. Window sills are cleaned
3. Glass tables and/or mirrors cleaned (no streaks)
4. Picture frames dusted
5. Light general straightening completed
6. Floors swept and mopped (or vacuumed)

Client Special Request-

This is to certify that I have read and will follow the 35 point checklist in all the homes I enter as a care-giver for 1st Premier.

Care-giver Name: _____ **Date:** _____

Care-giver Signature: _____



1st Premier
Home Care, Inc

Job Description

Title: Personal Care Worker/ Homemaker
(Unskilled)
Non-Exempt

Reports to: Consumer

Date:

General Purpose of Position

Under direct supervision is responsible for assisting clients with the tasks of daily living related to personal care and to home management. The primary goals are promotion of consumer dignity, independence, comfort, mobility, personal appearance, and safety.

Primary Duties and Responsibilities

Approx. % of time:	Duty or Responsibility
65	Personal care of the client: <ul style="list-style-type: none">• Assist with bathing in tub, shower, or with sponge bath• Assist with grooming to include care of hair, shaving, and ordinary care of nails (limited to filing and cleaning)• Oral care• Skin care• Dressing/undressing• Assisting individual to move on/off bedpan, commode, or toilet (unskilled transfer)
15	Light housekeeping <ul style="list-style-type: none">• Floor care to include vacuuming, sweeping, and mopping• Dusting• Bathroom cleaning• Bed making and linen change• Laundry• Dishes

- Garbage and waste disposal

5	Meal Preparation
5	Documenting according to procedures all visits made and services provided to the consumer
3	Feeding (unskilled)
2	Transferring in/out of bed or to change position (unskilled)
2	Ambulation
2	Respite (relief of family members)
1	Medication reminder

Other Duties and Responsibilities

The consumer or his/her representative may make additional requests for services not described within this document. Such requests may be performed if on the care plan and if time allows during the visit. Must adhere to the policies and procedures of 1st. Should have the ability to respond appropriately in stressful situations.

Employees are held accountable for all duties of this job

Responsibility for Work of Others

No Supervisory responsibilities are associated with this position

Responsibility for Interpersonal Contacts

Attendants should be able to communicate effectively. The Attendant must maintain strict consumer confidentiality at all times.

Potential Impact of Work on the Organization

It is the responsibility of the attendants to adhere to the agency's policies and procedures to prevent any potential negative impacts in the future.

Position Qualifications: Education/Formal Training

- N/A

Licenses, Certificates, Registrations

- 1st will provide training and certification where applicable

Work Experience

- Experience in the field of home health care is preferred, but not required skills
- Must have ability to successfully complete quizzes given upon subject matters covered during orientation
- Must have ability to speak clearly and effectively in a variety of settings
- Must have ability to follow written and/or oral instructions
- Must have a record of reporting to work consistently and on time
- Must have own transportation to include valid driver's license, current auto insurance and reliable vehicle, or a workable plan alternate transportation.

Physical Demands

While performing the duties of this position, the employee will be required to perform tasks involving physical activity common to ordinary personal care and household chores. Assisting with homemaking should not exceed 15 lbs. There may be bending, and prolonged standing associated with this position. Must have own transportation to include valid drivers license, current auto insurance and reliable vehicle or a workable plan for alternate transportation.

Work Environment

Flexible work schedule to include days/nights, weekdays, and some required weekends. 1st does not schedule in shifts or guarantee hours.

This job description is not intended, and should not be construed, to be an exhaustive list of all responsibilities, qualifications, or working conditions associated with this position.

Printed Name _____

Employee Signature _____

1st Premier Home Care IHSS Orientation

What is IHSS –

- Participant directed service delivery option
- Available in the Elderly Blind and Disabled (EBD), Spinal Cord Injury (SCI), and Children's Home and Community Based Services (HCBS) Waivers
- Employer Authority

Client Responsibilities/Rights –

- Select Attendants
- Train Attendants
- Schedule Attendants
- Dismiss Attendants
- Directly schedule, Manager & Supervisor staff
- Notify agency of permanent schedule changes
- Determine the level of oversight

Characteristics of IHSS- -

- Allows Client to Select, Schedule and Manage Attendants –
- Peer Counseling –
- 24-hour Back-up Services Provided
- Nursing Staff Available to Provide Support
- Agency Manages Attendant Reimbursement –
- Clients may receive skilled care from Attendants without a CNA or nursing license because Nurse Practice Act and Nurse Aide Legislation are waived –
- If there is a need for skilled care, clients can choose to access IHSS HMA or Long-Term Home Health, depending on client preference
- Functional Skills Training

Limitations of IHSS –

- A family member cannot provide more than 40 hours of personal care or home maker tasks in one week (NEW)
- Health Maintenance is the only IHSS service offered on the HCBS Waiver –
- A family member shall not be reimbursed for providing only IHSS Homemaker Services
 - o A family member may perform homemaker tasks which are secondary and contiguous to IHSS Health Maintenance Activities. Additional service hours will not be authorized to complete homemaker tasks
 - o Family members are not eligible to be the client's IHSS homemaker
 - o Authorized Representatives cannot be providers

Role of IHSS Agency IHSS Agency Must:

- Provide 24-hour back up services

- Provide Attendant Basic Training or Skills Validation within 30 days after services begin
- Provide Intake and Orientation
- In consultation with the client, contact the client's physician and receive direction as to the appropriateness of continued care in the event of the observation of new symptoms or worsening condition (new)
- Collaborate with the client to determine the level of oversight

IHSS Agency Must Complete the IHSS Care Plan

- A statement of allowable attendant and personal care service hours
- A detailed listing of amount, scope and duration of each service to be provided for each day
- Documentation that adequate staffing including backup staff will be available to provide necessary services
- A dispute resolution process
- Level of oversight
- Who will be providing each service

IHSS Agency Must Offer and Document if the Following Supports were Accepted or Declined in IHSS Care Plan:

- Functional Skills Training –
- Assistance with Attendant selection
- Peer Counseling
- Independent living core services—As defined at 26-8.1-102 (3), C.R.S.

Caregiver Signature

Date



1st Premier
Home Care, Inc

Job Description

Title: Health Maintenance Attendant (Skilled)	Reports to: Consumer
Full Time-Non-Exempt	Date:

General Purpose of Position

Under the direction of the consumer is responsible for providing a variety of routine and advanced consumer care tasks. Attendants also assist with basic activities and daily living needs of consumer. The primary goals are promotion of consumer dignity, independence, comfort, mobility, personal appearance, and safety.

Primary Duties and Responsibilities

Approx. % of time:	Duty or Responsibility
65	<p>Skilled Care:</p> <ul style="list-style-type: none">• Skin care and check• Assist with self-administered medications by opening a medication bottle or pillbox to aid the consumer with obtaining the amount of the medication desired. The Attendant may read the instructions on the label to the consumer if the correct dosage is questioned.• O2 check• Transferring in/out of bed or to change position by means of Hoyer, Slide Board, Gait Belt, Stand by, or Pivot devices.• Assist with ambulation/walker• Assist with range of motion• Assisting individual to move on/off bedpan, commode, or toilet• Assist with toileting by administering rectal stimulation or suppository• Empty and clean leg/catheter bag• Blood Pressure/Vital signs

- Assisting with bathing in bed, tub, shower, or with sponge bath
- Assisting with grooming to include care of hair, shaving, and ordinary care of nails
- Oral care
- Dressing/undressing

10

Light Housekeeping

- Floor care to include vacuuming, sweeping, and mopping
- Dusting
- Bathroom cleaning
- Bed making and linen change
- Laundry
- Dishes
- Garbage and waste disposal

3

Meal Preparation (special diet)

5

Documenting according to procedures all visits made and services provided to the consumer

2

feeding

Other Duties and Responsibilities

The consumer or his/her representative may make additional requests for services not described within this document. Such requests may be performed if on the care plan and if time allows during the visit.

Must adhere to the policies and procedures of 1st. Should have the ability to respond appropriately in stressful situations.

Employees are held accountable for all duties of this job

Responsibility for Work of Others

No Supervisory responsibilities are associated with this position

Responsibility for Interpersonal Contacts

Attendants should be able to communicate effectively. The Attendant must maintain strict consumer confidentiality at all times.

Potential Impact of Work on the Organization

It is the responsibility of the attendants to adhere to the agency's policies and procedures to prevent any potential negative impacts in the future.

Position Qualifications: Education/Formal Training

- Basic First Aid Training

Licenses, Certificates, Registrations

- Current CPR certification is preferred, but not required

Work Experience

- Experience in the field of home health care is preferred, but not required

Skills

- Must have ability to successfully complete quizzes given upon subject matters covered during orientation
- Must have ability to speak clearly and effectively in a variety of settings
- Must have ability to follow written and/or oral instructions
- Must have a record of reporting to work consistently and on time
- Must have ability to listen attentively and actively

Physical Demands

While performing the duties of this position, the employee will be required to perform tasks involving physical activity common to ordinary personal care and household chores. Assisting with homemaking should not exceed 15 lbs. There may be bending, and prolonged standing associated with this position. Must have own transportation to include valid drivers license, current auto insurance and reliable vehicle or a workable plan for alternate transportation.

Work Environment

Flexible work schedule to include days/nights, weekdays, and are required to work every other weekend at a minimum. 1st does not schedule in shifts or guarantee hours.

This job description is not intended, and should not be construed, to be an exhaustive list of all responsibilities, qualifications, or working conditions associated with this position.

Printed Name _____

Employee Signature _____



1st Premier
Home Care, Inc

Job Description

Title: Health Maintenance Attendant (Skilled)	Reports to: Consumer
Full Time-Non-Exempt	Date:

General Purpose of Position

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Primary Duties and Responsibilities

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- Assisting with bathing in bed, tub, shower, or with sponge bath
- Assisting with grooming to include care of hair, shaving, and ordinary care of nails
- Oral care
- Dressing/undressing

10

Light Housekeeping

- Floor care to include vacuuming, sweeping, and mopping
- Dusting
- Bathroom cleaning
- Bed making and linen change
- Laundry
- Dishes
- Garbage and waste disposal

3

Meal Preparation (special diet)

5

Documenting according to procedures all visits made and services provided to the consumer

2

feeding

Other Duties and Responsibilities

The consumer or his/her representative may make additional requests for services not described within this document. Such requests may be performed if on the care plan and if time allows during the visit.

Must adhere to the policies and procedures of 1st. Should have the ability to respond appropriately in stressful situations.

Employees are held accountable for all duties of this job

Responsibility for Work of Others

No Supervisory responsibilities are associated with this position

Responsibility for Interpersonal Contacts

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Licenses, Certificates, Registrations

- Current CPR certification is preferred, but not required

Work Experience

- Experience in the field of home health care is preferred, but not required

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- Must have ability to successfully complete quizzes given upon subject matters covered during orientation
- Must have ability to speak clearly and effectively in a variety of settings
- Must have ability to follow written and/or oral instructions
- Must have a record of reporting to work consistently and on time
- Must have ability to listen attentively and actively

Physical Demands

While performing the duties of this position, the employee will be required to perform tasks involving physical activity common to ordinary personal care and household chores. Assisting with homemaking should not exceed 15 lbs. There may be bending, and prolonged standing associated with this position. Must have own transportation to include valid drivers license, current auto insurance and reliable vehicle or a workable plan for alternate transportation.

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Printed Name _____

Employee Signature _____



1st Premier Home Care, Inc

1st Premier Home Care and Attendants Services 34 point cleaning checklist is here to assist our attendants. We specialize in the care of all our clients from skilled services to home care assistance. We as a team will only benefit from using this checklist to create a clean, comfortable, and safe home environment for our clients.

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Kitchen-

1. Countertops and backsplash cleaned (all items removed and then replaced)
2. Clean the outside of the appliances (oven, microwave, dishwasher, fridge, and stove)
3. Window sills cleaned
4. Small appliances wiped down (toaster, coffee maker, mixer, etc.)
5. Trash emptied
6. Dishes washed or dishwasher loaded (if it is a small load of dishes, wash them by hand, dry them and put them away)
7. Wash or dust tables and chairs
8. Floor swept and mopped (or vacuumed)
9. At least once a week, go through the refrigerator to make sure there are no spills, expired food/drinks, or food that is not stored properly. If there are, throw out the food and clean out the fridge.

Bathrooms-

1. Sink thoroughly cleaned, disinfected and rinsed
2. Tub and/or shower tiles thoroughly cleaned, disinfected and rinsed
3. Sink and tub/shower fixtures cleaned and shined
4. Mirrors cleaned (no streaks)
5. Window sills are cleaned
6. Vanity top cleaned (remove and replace items)
7. Towels changed if needed or requested
8. Trash emptied
9. Toilets cleaned and disinfected (inside and out)
10. Floor swept and mopped (or vacuumed)

Bedroom-

1. Linens changed if needed or requested
2. Beds made
3. All areas dusted-on top, in front and underneath (remove and replace items)
4. Picture frames dusted
5. Mirrors cleaned (no streaks)
6. Window sills are cleaned
7. Trash emptied
8. Baseboards dusted (if needed)
9. Light general straightening completed
10. Floor swept and mopped (or vacuumed)

Other Living Areas-including hallways and stairs-

1. All areas dusted-on top, on front, and underneath (all items removed and then replaced)
2. Window sills are cleaned
3. Glass tables and/or mirrors cleaned (no streaks)
4. Picture frames dusted
5. Light general straightening completed
6. Floors swept and mopped (or vacuumed)

Client Special Request-

This is to certify that I have read and will follow the 35 point checklist in all the homes I enter as a care-giver for 1st Premier.

Care-giver Name: _____ **Date:** _____

Care-giver Signature: _____