Dear Applicant,

Enclosed, please find your application to become a member of our Home Care team. Please complete all forms, sign and date them, and return them back to the Marquis office. It can be emailed, faxed, or mailed to me at the address below.

Marquis Home Care
230 North Main Street
Spring Valley, NY 10977
Attn: Leah Holczler
Phone: (845) 205-9675
Fax: (845) 746-9915
Email: Lholczler@marquishc.com

Please remember to include the following:
-2 Reference letters
- must include contact information of the person writing letter, signature and date
-NY state IDS, 2 are required
-Medicals: a current physical no less than 12 months old with PPD, titers, and Drug screen

To ensure speedy employment, please make sure that you have all required information completed. Should you have any questions or need additional information, do not hesitate to contact me.

Sincerely,
Leah Holczler
Human Resources Department

Marquis Home Care
Home Health Aide Training Program
Student Registration and Enrollment Agreement

Last	First	MI	Gender
			Male ☐ Female ☐
Driver's license number and State of Issuance	***Social Security Number (SSN)**	**Date of birth**	**Height**

Mailing Address:		
City	**State**	**Zip**

Home Phone	**Cell Phone**

In case of emergency, who should be contacted?	
Name	Relationship
Home Phone	Cell Phone

1. How did you hear about the course? _____

2. Are you at least 18 years old? Yes☐ No☐

3. Have you ever had experience working in home care? Yes☐ No☐

4. Are you currently employed? Yes☐ No☐ If yes, where? _____

5. Do you read and/or understand English? Yes☐ No☐

6. Have you ever been convicted by any court of law of a crime other than a minor traffic violation? Yes☐ No☐

If yes, explain _____

This agreement is a legally binding instrument when signed by the student and accepted by the program. **"Home Health Aide Training Program",** a 75 hour course, in English only. The program is designed to prepare the student to provide quality care to clients in their homes. Upon successful completion, student will qualify to be a Home Health Aide.

Location_____ Starting Date_____

AGREEMENT: My signature below certified that I have read, understand, and agree to my rights and responsibilities and that the Marquis Home Care (MHC) Training Program policies have been clearly explained to me. **I AGREE**: To release and hold harmless MHC and any Health Care Facility/Agency, which provides my clinical experience, its employees and clients, from my misconduct or accident that occur as a result of my participation in the Home Health Aide Training Program. I voluntarily agree to attend MHC HHATP and understand that there is no reimbursement for time spent in the training program.

X_____
Signature of Student Date

X_____
Signature of Director Date

This document will be retained in the students' record for five years

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 746-9930

Application for Employment

FOR OFFICE TO COMPLETE:
Hire Date _____ Company_____

FOR APPLICANT TO COMPLETE**:**

Today's Date_____

Name: _____ Social Security #_____

Present address: Date of Birth: _____

Street: _____ Apt #_____

City: _____ State: _____ Zip Code: _____

Phone # _____ Cell# _____

Cell Phone Carrier _____ Email: _____

In case of Emergency notify:
Name: _____ Phone # _____

Address: _____ Relationship_____

How did you hear about our agency? ☐ Indeed ☐ Walk in ☐ Recruiter ☐ Other: _____

If you are under 18, can you furnish a work permit? ☐Yes ☐ No

Position_____ Date you can start_____ Salary_____

Are you currently employed?_____ If so, may we contact your present employer? ☐Yes ☐No

Are you on layoff and subject to recall? ☐Yes ☐No Will you travel if required? ☐Yes ☐No

Will you relocate if job requires it? ☐Yes ☐No Will you work overtime if required? ☐Yes ☐No

Are you able to meet the attendance requirements of this position? ☐Yes ☐No

Have you ever been Bonded? ☐Yes ☐No

Have you ever been convicted of a felony in the past 7 yrs ☐Yes ☐No

Summarize special skills and qualifications acquired from employment or other experiences that may qualify you to work with this company:

_____

_____

Please list any foreign languages that you know: _____

_____

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 746-9930

INITIAL **Conditions of Employment – please read carefully**

_____ Reporting to work with impaired abilities; or the possession, consumption or distribution of drugs or alcohol on company premises and/or worksites, shall be grounds for disciplinary action, including discharge. A condition of employment includes willingness on the part of the applicant or employee to agree to physical examination, polygraph and/or substance testing, if required by the company. We are committed to operating a drug free workplace. Violations of our drug and alcohol policy will result in dismissal.

_____ It is understood and agreed upon that any misrepresentation by me in this application will be sufficient cause for cancellation of this application and/or separation from the employer's service, if I have been employed. Furthermore, I understand that just as I am free to resign anytime, the Employer reserves the right to terminate my employment at any time, with or without cause and without prior notice. I understand that no representative of the Employer has the authority to make any assurances to the contrary.

_____ I give the employer the right to investigate all police, driving, and personal records and references, if job related. I hereby release from liability the Employer and its representatives for seeking such information and all other persons, corporations or organizations for furnishing such information.

____ The Employer is an Equal Opportunity Employer. The Employer does not discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant's consideration for employment on a basis prohibited by local, state or federal law.

____ Any controversy of any kind arising between the parties under this agreement or otherwise (or any agent, officer, director or affiliate of any party), including but not limited to common law, statutory, tort or contract claims, will be submitted to mediation, and failing settlement in mediation, to binding arbitration. Unless otherwise agreed, a mediation and arbitration designated by staff professionals will govern any mediation and arbitration. The parties will select the mediator or arbitrator from the designated company.
Panel of mediators and will notify the designated company, in writing, to initiate the selection process. The arbitration will be subject to and governed by the provisions of the Federal Arbitration Act. 9 U.S.C. Section 1-et seq. The parties hereto stipulate that this agreement involves matters affecting interstate commerce.

____ This application is current for 60 days. At the conclusion of this time, if I have not heard from the Employer and still wish to be considered for employment, it will be necessary to fill out a new application.

_____ _____

Signature of Applicant **Date**

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 363-8141

EMPLOYEE NAME: _____

PRINT NAME

Drug Screening and Inspection Consent Form

DRUG FREE WORKPLACE

The Agency has a policy against drug and alcohol abuse and reserves the right to screen its employees as an enforcement measure in providing a safe, healthy, and productive working environment.

1.By my signature below, I am freely and voluntarily agreeing and consenting to submit a personal specimen of urine for chemical analysis and testing to determine the presence of any illegal, abused, or prohibited drugs/alcohol or substances in my body fluids, on a random basis as well as annual testing and for-cause testing. I understand that my refusal to submit a specimen of my urine for testing upon request will be grounds for my dismissal.

2.I hereby authorize the agency's duly appointed collection facility, and their personnel, to obtain, process, and test the specimen and to release and discuss the results of the analysis and test to the Director of Human Resources or designee for employment purposes. Said information will be handled as confidentially as is reasonably possible, shared only on a "need to know" basis.

3.I understand a documented chain of custody will be created to ensure the identity and integrity of my specimen throughout the collection and testing process.

4.As an employee, I understand if I have a positive test or refuse to submit to this drug/alcohol screening analysis and test, this will constitute a violation of the agency's policy and I will be subject to disciplinary action up to and including termination of employment. I understand that at the time of drug testing, I will be required to show copies of prescriptions for drugs prescribed and taken within the last thirty (30) days.

5.I hereby release, forever discharge, and hold harmless the agency , any physician, technician, medical facility and laboratory facility and all of their respective officers, directors, employees, representatives, and agents from any and all claims of whatever nature arising out of or in connection with any act or omission relating to any (1) examination, (2) test, (3) collection, (4) procedure, (5) chain of custody, (6) disclosure, (7) analysis, (8) diagnosis, (9) inaccuracy,(10) report, or (11) action performed. This release applies to any negligence, sole negligence, comparative negligence, concurrent negligence, gross negligence, recklessness, wantonness, willfulness, error, act, or omission of any of the individuals or entities covered hereby.

6.I understand and acknowledge that I will be required to allow the agency to search my person, personal effects, vehicle/ and other property located on agency premises or worksites, including agency vehicles and private vehicles located at the agency's premises or worksites. I also understand and acknowledge that my refusal to allow such searches to occur will be grounds for my immediate dismissal.

I HAVE READ AND UNDERSTAND THE ABOVE AND WILL COMPLY WITH THIS AGREEMENT.

_____ _____

Employee Signature ***Date***

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 363-8141

CONFIDENTIALITY OF INFORMATION AGREEMENT

EMPLOYEE NAME: _____
PRINT NAME

Confidentiality of Information

- All information designated confidential that is obtained or generated as a result of any or all of the operations of the agency will be dealt with in a confidential manner.
- All information that is gathered maintained or stored by the agency becomes the agency's property and cannot be released without proper authorization from the administration.
- Altering information is prohibited by the agency and by law. Correction of any identified erroneous information must be done according to agency policy.

WHAT WE CAN DO TO MAINTAIN CONFIDENTIALITY OF INFORMATION

- In order to protect any individual from invasion of privacy and to protect the interest of the agency, any information gathered for patient care or operations will be gathered, maintained and stored in such a manner as to assure confidentiality.
- Access to information will be limited to a need to know basis to perform the scope of one's duties and responsibilities.
- Dissemination of information will be handled according to agency policy, and staff will be informed during orientation, will sign the confidentiality statement and it will be placed in the employee's file.
- Proven violation of breech of the confidentiality agreement may be cause for immediate termination.

I understand that I am responsible for following this Confidentiality Policy Agreement & The Guidelines, Both Written and Verbal.

_____ _____

Employee Signature ***Date***

Permanent Residential Addresses

As per DOH regulations and in accordance with OCS statutes, please list **all** permanent residential addresses since birth, Including the month and year of residency.

1) _____
_____

2) _____
_____

3) _____
_____

4) _____
_____

5) _____
_____

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 363-8141

PERSONAL REFERENCE

Please provide the following information of one individual not related to you, to whom you have known at least one year

Name: _____

Phone: _____

Address: _____

City/Town: _____ **State:** _____ **Zip:** _____

APPLICANT NAME: _____

The above named applicant has applied for employment with our agency and requests/authorizes you to release all information below under the provisions of the Privacy Act of 1974. All information will be held in strict confidence.

_____ _____

Signature of Applicant **Date**

STOP – OFFICE USE ONLY

EVALUATION: Please check one for each statement

	YES	MOST OF THE TIME	SOME OF THE TIME	NO
Is this person dependable?				
Is this person trustworthy?				
Does this person follow instructions?				
Is this person cooperative?				
Does this person have a positive attitude toward others?				
Is this person able to cope with difficult situations?				

How long have you known this person? _____

Additional comments: _____

_____

Signature_____ **Date** _____

Verbally verified by _____ **Date**_____

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 363-8141

PROFESSIONAL REFERENCE

Name: _____

Agency/ Company Name: _____

Phone: _____ **Fax:** _____

Address: _____

City/Town: _____ **State:** _____ **Zip:** _____

The undersigned has applied for employment with our company and authorizes you to provide information concerning past performance under the provisions of the Privacy Act of 1974. All information is kept confidential.

APPLICANT NAME: _____ ***S.S.#*** _____

DATE: _____ **APPLICANT SIGNATURE:** _____

Please, do not complete anything below this line

==========

Please complete and sign

EMPLOYMENT DATES: From _____ To _____ POSITION: _____
Month/Yr. Month/YR.

REASON FOR LEAVING: _____

WOULD YOU REHIRE? ☐ YES ☐ NO

COMMENTS: _____

_____

_____

SIGNATURE: _____ **DATE:** _____

POSITION OR TITLE: _____ wkref

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 363-8141

PROFESSIONAL REFERENCE

Name: _____

Agency/ Company Name: _____

Phone: _____ **Fax:** _____

Address: _____

City/Town: _____ **State:** _____ **Zip:** _____

The undersigned has applied for employment with our company and authorizes you to provide information concerning past performance under the provisions of the Privacy Act of 1974. All information is kept confidential.

APPLICANT NAME: _____ ***S.S.#*** _____

DATE: _____ **APPLICANT SIGNATURE:** _____

Please, do not complete anything below this line

==========

Please complete and sign

EMPLOYMENT DATES: From _____ To _____ POSITION: _____
Month/Yr. Month/YR.

REASON FOR LEAVING: _____

WOULD YOU REHIRE? ☐ YES ☐ NO

COMMENTS: _____

_____

_____

SIGNATURE: _____ **DATE:** _____

POSITION OR TITLE: _____ wkref

DOH CHRC 102 (1/07)

NYS Department of Health
ACKNOWLEDGEMENT AND CONSENT FORM FOR FINGERPRINTING AND DISCLOSURE OF CRIMINAL HISTORY RECORD INFORMATION
THIS FORM IS TO BE RETAINED BY THE AGENCY- DO NOT FORWARD TO THE DOH CHRC UNIT.
chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

LAST Name	FIRST Name	M.I.	
Date of Birth (mm/dd/yyyy)	Mother's Maiden Name	Alias: AKA	

Mailing Address (street)	City	State	Zip

SECTION 2 - ATTESTATION

1. I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).

2. I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.

3. I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary to be provided to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, as maintained by DCJS or the FBI, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. I have been advised that by law, DOH is authorized and may be required to provide the results of the criminal history record check through a criminal history record summary to the agency. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law.

4. I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.

5. I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI.

6. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.

7. I certify to the best of my knowledge and belief that I (check as appropriate):
   - ☐ **Have** ☐ **Have not been convicted of a crime in New York State or any other jurisdiction**
   - ☐ **Do** ☐ **Do not have a final finding of patient or resident abuse**

   If you have checked either "Have" and/or "Do", please provide a brief explanation. (Optional)
   _____

8. My current mailing or home address is indicated in Section 1 of this form.

9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the redisclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own (not applicable for Expedited Review submitted pursuant to CHRC Form 104).

Applicant Signature: _____ Date: _____

Signature of Parent or Legal Guardian_____ Date: _____
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name:	PFI/Operating License Number:
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date:

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 363-8141

Employee's Information for Fingerprint Request

Date: _____

Print Name: _____

Address: _____

City/State/Zip: _____

DOB: _____

Last 4 of Social: _____

Maiden Name: _____

Telephone #: _____

Place of Birth (Country): _____

Gender: _____

Race: _____

Height: _____

Weight:_____

Color of Eyes:_____

Color of Hair:_____

Citizenship: _____

Form W-4 (2019)

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

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. ***Head of household please note:*** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

---

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2019

1 Your first name and middle initial	Last name	**2 Your social security number**
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

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

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

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

Labor Law Section 195(1)
Notice and Acknowledgement of Wage Rate and Designated Payday
Hourly Rate Plus Overtime

Employer	**Employee**
Company Name The Eliot at Erie Station FEIN _____ LHCSA Street address _ 12 John Street City _____ Middletown, NY Zip _____ 10940 Phone (_____ Human Resources Preparer's Nam (845) 363-8140 Preparer's Title Casey DeZorett	Name _____ Street address _____ Apt. _____ City _____ State _____ Zip: _____ Phone (_____) _____ - _____

Your rate of pay: Rockland- $11.10, Dutchess- $12.00, Orange - $11.10, Westchester/Suffolk- $14.22, 5 Boroughs- $17.09 per hour.

Your overtime rate of pay: Rockland- $16.65, Dutchess- $18.00, Orange - $17.25, Westchester/Suffolk- $22.83, 5 Boroughs- $28.63 per hour.

Designated pay day: Weekly/Thursdays

I hereby certify that I have read the above and the information contained in this form is true and accurate to the best of my knowledge and belief. Any false statements knowingly made are punishable as a class A misdemeanor (Section 210.45 of the New York State Penal Law).

Date: _____ _____
[Preparer's Signature]

General Statement Regarding Overtime Pay in New York:
Almost all employees in New York must be paid overtime wages of 1½ times their regular rate of pay for all hours worked over 40 per workweek. A very limited number of specific categories of employees are covered by overtime at a lower overtime rate or not at all.

I hereby acknowledge that I have been notified of my wage rate, overtime rate, and designated pay day on the date set forth below.

Date: _____ _____
[Employee's Signature]

A duplicate signed copy of this form is to be provided to the employee. Original must be kept by the employer.

LS 52 (10/09)

Labor Law Section 195(1)
Notice and Acknowledgement of Wage Rate and Designated Payday
Hourly Rate Plus Overtime

Employer	**Employee**
Company Name Marquis Home Care FEIN 46-0644572 Street address 230 North Main Street, Spring Valley, NY10977 City (845) 363-8140 Zip Casey DeZorett Phone ( ) - Human Resources Preparer's Name Preparer's Title	Name Street address Apt. City State Zip: Phone ( ) -

Your rate of pay: Rockland- $11.10, Dutchess- $12.00, Orange - $11.50, Westchester/Suffolk- $15.22, 5 Boroughs- $19.09 per hour.

Your overtime rate of pay: Rockland- $16.65, Dutchess- $18.00, Orange - $17.25, Westchester/Suffolk- $22.83, 5 Boroughs- $28.63 per hour.

Designated pay day: Weekly/Fridays

I hereby certify that I have read the above and the information contained in this form is true and accurate to the best of my knowledge and belief. Any false statements knowingly made are punishable as a class A misdemeanor (Section 210.45 of the New York State Penal Law).

Date: _____ _____
[Preparer's Signature]

General Statement Regarding Overtime Pay in New York:
Almost all employees in New York must be paid overtime wages of 1½ times their regular rate of pay for all hours worked over 40 per workweek. A very limited number of specific categories of employees are covered by overtime at a lower overtime rate or not at all.

I hereby acknowledge that I have been notified of my wage rate, overtime rate, and designated pay day on the date set forth below.

Date: _____ _____
[Employee's Signature]

A duplicate signed copy of this form is to be provided to the employee. Original must be kept by the employer.

LS 52 (10/09)

THIS WAIVER is made as of the ___day of _____, 20__, between Marquis Home Care, the company, having its principal place of business at 230 North Main Street, Spring Valley, NY 10977, and _____, of _____, the Employee.
[Employee Name] [City, State]

WHEREAS the Employer desires to obtain the benefit of the services of the Employee, and the Employee desires to render such services on the terms and conditions set forth. IN CONSIDERATION of the promises and other good and valuable consideration, the parties agree as follows:

1. Employment-The Employee, referenced throughout as "Employee" agrees that they will at all times faithfully, industriously, and to the best of their skills, experience and talents, perform all of the duties required of the position with the company for a minimum of 3 months. In carrying out these duties and responsibilities, the Employee shall comply with all Employer policies, procedures, rules, and regulations, both written and oral, as are announced by the Employer from time to time.

2. Employer -The Employer, referenced throughout as "Employer" agrees to provide the training free of charge ($100 value) with the understanding that Employee must provide care for a minimum of three months.

3. Probationary Period-It is understood and agreed that the first 90 days of employment shall constitute a probationary period. During this probationary period, the Employer retains the right to exercise at will employment at any time and may terminate the Employee at any time without notice or cause.

4. At Will Employment-While we look forward to a long and successful relationship, you will be an at will employee of the Employer, which means the employment relationship can be terminated by either of us for any reason, at any time, with or without prior notice and with or without cause. Any statements or representations to the contrary (and, indeed, any statements contradicting any provision in this contract) should be regarded by you as ineffective.

The Employee may at any time terminate this contract and employment by giving not less than 2 weeks written notice to the Employer. The Employee agrees to return any and all property of the Employer at the time of termination. Should the Employee terminate employment prior to the end of the 90-day probationary period, the Employee will be required to pay the aforementioned waived $100 training course fee.

_____ _____
Name of Employee Date

_____ _____
HR Representative Date

HHA/PCA ORIENTATION

230 N. Main Street, Spring Valley, NY 10977

Employee Authorization for the Release of Medical Information

I, _____, do hereby authorize any physician, dentist, chiropractor, therapist, clinic, hospital or other health care provider or administrative staff, to release to *Marquis Home Care,* all medical records related to my examination, evaluation, and/or treatment by such health care provider including but not limited to, the following:

1. All clinical records;
2. Results of all laboratory tests, including x-rays;
3. Records of all prescribed medications and treatments;
4. All correspondence between my doctors or their administrative staffs or the administrative staffs of all hospitals, clinics, or other medical treatment centers where I am, or have been, a patient or from whom I received medical care;
5. All correspondence either by facsimile, electronic mail or hard copy between my doctors or their administrative staffs, or the administrative staffs of all hospitals, clinics, or other medical treatment centers where I am, or have been, a patient or from whom I have received medical care, and any insurance companies or their representatives concerning any claims made on my behalf for medical treatment or for benefits of any nature including, but not limited to, disability benefits, social security benefits, and Veteran's Administrative benefits;
6. All notes, correspondence, or other records of any nature made by my physicians, nurses, or any other persons concerning me, my condition, or my treatment.

A photocopy of the signed original of this "Authorization For Release of Medical Information" shall have the same force and effect as the original and shall be sufficient for the same purposes.

_____
Signature

_____
Witness

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 363-8141

HEPATITIS INFORMATION ACKNOWLEDGEMENT
ACCEPT OR DECLINATION STATEMENT

I have read and understand the information in the Hep B Packet. My signature below indicates my acknowledgement of this information and my decision to either accept the Hep B Vaccination or decline the Hepatitis B Vaccination program.

Only choose **ONE** option:

DECLINE

☐ I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I **decline** Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

☐ I have received the Hepatitis B Vaccination series, and **decline** vaccination at this time.

ACCEPT

☐ I **accept** this opportunity to participate in the Hep B program, which includes a series of 3 injections at 0, 30, and 180 day intervals. I will comply with the administration procedure and am aware of adverse effects, contraindications, and complications that may occur due to the Hepatitis B Vaccination.

Employee Signature:_____ Date_____

Name (Print):_____

Agency Representative Signature_____ Date_____

Declination of Influenza Vaccination for Health Care Personnel

Employee's Name: _____ Employee's ID#: _____

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider.

I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect this agency's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear.
- My shedding the virus can spread influenza to patients in this agency.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this agency, coworkers, my family and my community.

- **Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients may be present during the influenza season.**

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature: _____ Date: _____

HR Representative: _____ Date: _____

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 363-8141

Employee Name: _____

ANNUAL TUBERCULOSIS QUESTIONNAIRE

For personnel who have a known positive PPD or whole blood assay are required to complete this questionnaire with either a yes or no.

HAVE YOU NOTICED ANY OF THE FOLLOWING?

1. Unexplained fevers	☐ **Yes** ☐ **No**
2. Night Sweats	☐ **Yes** ☐ **No**
3. Unintentional weight loss	☐ **Yes** ☐ **No**
4. Cough	☐ **Yes** ☐ **No**
5. Hoarseness	☐ **Yes** ☐ **No**
6. Bloody Sputum	☐ **Yes** ☐ **No**
7. Have you completed INH therapy?	☐ **Yes** ☐ **No** If Y, Date of Completion :_____
8. Have you ever had a BCG vaccine?	☐ **Yes** ☐ **No**
9. Have you had an x-ray while employed here?	☐ **Yes** ☐ **No**

_____ _____

Employee Signature ***Date***

For Office Use:

Follow-up needed ☐ **Yes** ☐ **No**

Comments: _____

_____

_____

_____

Agency Representative: _____ ***Date***_____

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Medical Documents Required

In order for your medical file to be complete, the following information must be submitted:

1. Physical:
    - Clearance clause must include employee is cleared to work as well as the Habituation part.
    - Vitals must be completed
    - Must have doctors stamp/license number
    - Must be dated within the last six months
2. PPD results:
    - A skin test must be performed: the date PPD was placed, date read, results in millimeters and results read should be documented. PPD needs to be read within 2-3 days of being placed.
    - A Quantiferon can also be performed in place of a PPD (Lab report showing your results, if you are negative/positive)
    - ❖ If PPD is positive:
        1- You must submit a form with the date you became positive
        2- They need to submit a chest x-ray that is clear
3. Proof of immunity to Rubella and Rubeola (Measles). You can submit it as follows:
    a. Lab report showing the immunity, it should include the reference range
    b. 2 MMR shots done more than a month apart, you just need the dates of shots, immunity and signature

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 746-9930

EMPLOYEE'S PHYSICAL EXAM FORM TO BE COMPLETED BY PHYSICIAN

Dear Doctor: Please complete this form on the following person. This information is mandatory for employment in the health field.

NAME _____ DATE OF BIRTH _____ GENDER: _____

HISTORY

	YES	NO		YES	NO		YES	NO
Heart Disease	[ ]	[ ]	Hepatitis	[ ]	[ ]	Diabetes	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	Alcohol/Drug	[ ]	[ ]	Thyroid	[ ]	[ ]
Back Problems, Injuries	[ ]	[ ]	Anemia	[ ]	[ ]	Seizure Disorder	[ ]	[ ]
Arthritis	[ ]	[ ]	Asthma	[ ]	[ ]	Hernia	[ ]	[ ]
Emotional or Mental Problems	[ ]	[ ]	Cancer	[ ]	[ ]	Poor Hearing	[ ]	[ ]
Poor Vision	[ ]	[ ]	Tuberculosis	[ ]	[ ]	Allergies	[ ]	[ ]

If yes, please describe: _____

_____

Previous medical illness or surgical procedures: _____

_____

PHYSICAL EXAM

Height: _____ Weight: _____ B/P: _____ Pulse: _____ Respirations: _____

SKIN _____ HEART _____

HEAD _____ LUNGS _____

EYES _____ ABDOMEN _____

ENT _____ BACK _____

NECK _____ EXTREMITIES _____

NEUROLOGIC _____

Please describe abnormalities (include any lifting restrictions): _____

_____

IMMUNIZATION HISTORY

[ ] PPD (Mantoux): Date Implanted _____ Manufacturer: _____ Lot #_____

Expiration date:_____ Date Read _____ Results _____(mm) Interpretation _____Read by:_____

[ ] **For Positive PPD or History of positive PPD, where PPD contraindicated**

[ ] Chest X-Ray: Date/Result: _____ (Attach original report)

TB Prophylaxis initiation date: _____, Completion date:_____

[ ] Rubella Titer -Attach lab report Date: _____ Result: _____ [ ] Immune

[ ] Rubeola Titer -Attach lab report Date: _____ Result: _____ [ ] Immune

OR:

[ ] Rubella Immunization (Only if titer shows no immunity): _____

[ ] Rubeola Immunization (Only if titer shows no immunity): 1st Dose _____ 2nd Dose _____

[ ] Influenza Vaccine Date: _____ Lot #_____

WORK CLEARANCE

The above named person is found to be in good mental/physical health. He/she is free from signs and symptoms of habituation or addiction to alcohol, depressants, stimulants, narcotics or other substances that may alter the person's behavior. He/she is free from any condition or communicable disease which could endanger his/her safety as well as the client.

Physician Signature _____ Exam Date _____

Stamp: _____ License No. _____

Submit