

CDPAS Application

Phone: (845) 363-8140 Fax: (845) 262-2836

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: _____

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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

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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 breach 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

CDPAS EXPLANATION

CDPAS is a program that allows consumers/patients to find, hire and train their own assistants and be reimbursed by Medicaid, through Social Services or a Managed Care Organization (MCO). These assistants, called CDPA, do not require certification and can provide any kind of personal or skilled care the consumer/patient and the assistant agree upon. The consumer is responsible for the training and performance of the CDPA. A nursing agency will initially assess the ability of the consumer to participate in this plan and reassess them every six months. The nursing agency will act as a fiscal intermediary, ensuring the CDPAs health status and processing their paycheck. Full explanation of rights and responsibilities can be found at www.health.ny.gov.

“consumer” means a patient who Social Services or MCO has determined eligible to participate in the consumer directed personal assistance program.

“consumer directed personal assistance” means the provision of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated representative.

“consumer directed personal assistant” (“CDPA”) means an adult who provides consumer directed personal assistance to a consumer under the consumer's instruction, supervision and direction or under the instruction, supervision and direction of the consumer's designated representative. A consumer's spouse, parent or designated representative may not be the consumer directed personal assistant for that consumer; however, a consumer directed personal assistant may include any other adult relative of the consumer who does not reside with the consumer or any other adult relative who resides with the consumer because the amount of care the consumer requires makes such relative's presence necessary.

“skilled nursing tasks” means those skilled nursing tasks that are within the scope of practice of a registered professional nurse or a licensed practical nurse and that a consumer directed personal assistant may perform pursuant to Section 6908 of the Education Law.

Consumer/Patient Responsibilities:

The consumer and, as applicable, the consumer's designated representative shall be solely responsible to:

1. Manage the plan of care authorized by the MCO
2. Notify the MCO or nursing agency of any changes in health requiring a higher level of care
3. Recruit and hire a sufficient number of CDPAs to provide authorized services as set forth in the plan of care authorized by the MLTC
4. Training, supervising and scheduling each CDPA;
5. Terminating the CDPA's employment with the consumer
6. Assuring that each CDPA completely and safely performs the personal care services, home health aide services and skilled nursing tasks included on the consumer's MCO approved plan of care

CDPA Responsibilities

1. Give all required documentation to the Agency
2. Confirm your weekly amount of hours from Agency
3. Get your schedule from the pt/caregiver
4. Get all of your training regarding pt care from the pt/caregiver.

Please Read and Sign

X _____

Agency's/Fiscal Intermediary Responsibilities

1. Process each CDPA's wages
2. Ensure that the health status of each CDPA is assessed per regulation.
3. Maintain records for each CDPA which shall include time sheets, required CDPA health assessments, and information needed for payroll processing and benefit administration.



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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)		Apt. Number	City or Town		State	ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][][] - [][] - [][][][]		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>	
<p><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></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	<p>QR Code - Section 1 Do Not Write In This Space</p>

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



LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 		<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.



Notice and Acknowledgement of Pay Rate and Payday/ Aviso de día de pago y tasas de pago según la Sección 195.1 de la Ley del Trabajo del Estado de Nueva York. Sección 195.1 de la Notificación de la Ley del Trabajo del Estado de Nueva York para empleados con tarifas por hora/Under Section 195.1 of the New York State Labor Law/ Bajo la Sección 195.1 de la Ley Laboral del Estado de Nueva York Notice for Hourly Rate Employees/Aviso de pagos de empleado

1. Employer Information / Informacion del empleador

Name/Nombre _____

Doing Business As (DBA) name(s)/ Nombre (S) de Negocios
como(DBA)/Nombre commercial: _____

FEIN (optional)/Número de identificación federal
(opcional): _____

Physical Address/ Dirección física: _____

230 N. Main Street Spring Valley NY 10977

Mailing Address/ Domicilio
Postal: _____

Phone/Telefono: _____

845-363-8140

2. Notice given/ Aviso dado:

- ☐ At hiring/AI contratar
☐ On or before February 1 / En o antes de 1 de Febrero
☐ Before a change in pay rate(s), allowances claimed
or payday. / / Antes de un cambio en la (s) tasa
(s) de pago indemnizaciones reclamadas o día de
pago. / Antes de que haya un cambio en la (s)
tasa (s) de pago, la asignación reclamada o el día
del pago.

**3. Employee's Pay Rate/Tasa de pago del
empleado:** Rockland- \$13.00, Dutchess-
\$13.00, Orange - \$13.00, Westchester/Suffolk-
\$16.22, 5 Boroughs- \$19.09

per hour/por horas _____

4. Allowances taken /Permisos tomados

- ☐ None/Ninguno
☐ Tips/Propinas _____ per hour/por hora
☐ Meals/Almuerzo _____ per meal/ por comida
☐ Lodging/alojamientos _____
☐ Other/otros _____

5. Regular payday/ Día de pago

Weekly/Viernes _____

6. Pay is/ El pago se realiza

- ☒ Weekly/Semanal
☐ Bi-weekly/Quincenal
☐ Other/Otros: _____

**7. Overtime Pay Rate/Tarifa de pago de hora
extras(mas de 40 horas a la semana)) :**

Rockland- \$20.50, Dutchess- \$20.50, Orange - \$20.50,
Westchester/Suffolk- \$24.33, 5 Boroughs- \$28.63
per hour/por hora (Esto debe ser al menos 1½
la tarifa regular del empleador, con pocas
excepciones.).

8. Employee Acknowledgement

/Reconocimiento de empleado: On this day, I
received notice of my pay rate, overtime rate (if
eligible), allowances, and designated payday in
English and my primary language. I told my
employer that my primary language is **Spanish**. En
este día, recibí notificación de mi tasa de pago, tasa
de horas extra (si es elegible), asignaciones y día de
pago designado en inglés y mi idioma principal. Le
dije a mi empleador que mi idioma principal es el
criollo haitiano. / Ese día, recibí notificación de mis
tasas de pago, horas extras (si reúne los requisitos),
asignaciones y mis días de pago elegidos en inglés y
en mi lengua materna. Le dije a mi empleador que
mi lengua materna es el Espanol.

Print employee name/Nombre del empleado

Employee Signature /Firma del empleado

Date/Fecha

Preparer Name and Title /Nombre y cargo del
preparador

**The employee must receive a signed copy of this
form. The employer must keep the original for 6
years. / El empleado debe recibir una copia de
este formulario firmado. El empleador debe
conservar el original por 6 años.**



Notice and Acknowledgement of Pay Rate and Payday/Avi ak Rekonesans Jou Pèyman ak To Pèyman
Under Section 195.1 of the New York State Labor Law/Sou Seksyon 195.1 nan Lwa Travay Eta Nouyòk la
Notice for Hourly Rate Employees/Avi pou Anplwaye k ap Touche Chak Èdtan yo

1. Employer Information / Enfòmasyon Sou Anplwayè

Name/Non:

Doing Business As (DBA) name(s)/ Non Komèsyal:

FEIN (optional)/Nimewo Idantifikasyon Federal (opsyonèl):

Physical Address/Adrès Fizik:

Mailing Address/Adrès Postal:

Phone/Telèfòn:

3. Employee's Pay Rate/To Pèyman Anplwaye

α: Rockland- \$13.00, Dutchess- \$13.00,
Orange - \$13.00, Westchester/Suffolk- \$16.22,
5 Boroughs- \$19.09
per hour/pa èdtan

4. Allowances taken /Alokasyon li pran

- ☐ None/Okenn
☐ Tips/Poubwa _____ per hour/pa èdtan
☐ Meals/Repa _____ per meal/pa repa
☐ Lodging/Lojman _____
☐ Other/Lòt bagay _____

5. Regular payday/Jou pèyman regilye

Weekly/Fridays _____

6. Pay is /Pèyman an fèt

- ☒ Weekly/Chak semèn
☐ Bi-weekly/Chak de semèn
☐ Other/Yon lòt fason: _____

7. Overtime Pay Rate/To Pèyman Pou Travay Sipleman (travay ki depase 40 èdtan nan yon semèn) :

Rockland- \$20.50, Dutchess- \$20.50, Orange - \$20.50,
Westchester/Suffolk- \$24.33, 5 Boroughs- \$28.63
per hour/pa èdtan (This must be at least 1½ times the worker's regular rate, with few exceptions.)/(Sa sipoze omwen 1 ½ fwa to regilye travayè a, ak kèk eksepsyon.

8. Employee Acknowledgement /Rekonesans

Anplwaye: On this day, I received notice of my pay rate, overtime rate (if eligible), allowances, and designated payday in English and my primary language. I told my employer that my primary language is **Haitian Creole**. /Nan jou sa a, mwen te resevwa yon avi sou to pèyman mwen, to travay sipleman (si m kalifye), alokasyon, ak jou ki chwazi pèyman mwen ann Angle ak lang manman mwen. Mwen te di anplwayè mwen lang manman mwen se **Kreyòl Ayisyen**.

Print employee name/Ekri non anplwaye a ak lèt yo dekolè

Employee Signature /Siyati Anplwaye a

Date/Dat

Preparer Name and Title /Non ak Tit moun kap prepare dokiman an

2. Notice given/ Yo bay avi α:

- ☐ At hiring/Lè yo anplwaye a
☐ On or before February 1 / 1ye fevriye oswa avan sa
☐ Before a change in pay rate(s), allowances claimed or payday. / Avan gen yon chanjman nan to pèyman an (yo), alokasyon yo reklame oswa jou pèyman an.

The employee must receive a signed copy of this form. The employer must keep the original for 6 years. /Anplwaye a dwe resevwa yon kopi fòm sa a ki siyen. Anplwayè a dwe kenbe orijinal la pandan 6 ane.

Employee's Withholding Certificate**2020**

- ▶ **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 online estimator, and privacy.

**Step 2:
Multiple Jobs
or Spouse
Works**

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

Do **only one** of the following.

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

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

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

**Step 3:
Claim
Dependents**

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

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

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

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

**Step 4
(optional):
Other
Adjustments**

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

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

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

**Step 5:
Sign
Here**

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

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

**Employers
Only**

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

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

First name and middle initial		Last name		Your Social Security number	
Permanent home address (number and street or rural route)			Apartment number		Single or Head of household <input type="checkbox"/> Married <input type="checkbox"/>
City, village, or post office			State	ZIP code	Married, but withhold at higher single rate <input type="checkbox"/>
Note: If married but legally separated, mark an X in the <i>Single or Head of household</i> box.					
Are you a resident of New York City? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you a resident of Yonkers? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Complete the worksheet on page 4 before making any entries.					
1 Total number of allowances you are claiming for New York State and Yonkers, if applicable (from line 20)				1	
2 Total number of allowances for New York City (from line 35)				2	
Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.					
3 New York State amount				3	
4 New York City amount				4	
5 Yonkers amount				5	

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature	Date
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Penalty – A penalty of \$500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: Keep this certificate with your records.

Mark an **X** in box A and/or box B to indicate why you are sending a copy of this form to New York State (see instructions):

A Employee claimed more than 14 exemption allowances for NYS A ☐

B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay (mm-dd-yyyy) (see instr.):

Are dependent health insurance benefits available for this employee? Yes ☐ No ☐

If Yes, enter the date the employee qualifies (mm-dd-yyyy):

Employer's name and address (Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)	Employer identification number
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Instructions**Changes effective for 2020**

Form IT-2104 has been revised for tax year 2020. The worksheet on page 4 and the charts beginning on page 5, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2020 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If the federal Form W-4 you most recently submitted to your employer was for tax year 2019 or earlier, and you do not file Form IT-2104, your employer may use the same number of allowances you claimed on your federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

For tax years 2020 or later, withholding allowances are no longer reported on federal Form W-4. Therefore, if you submit a federal Form W-4 to your

employer for tax year 2020 or later, and you do not file Form IT-2104, your employer may use zero as your number of allowances. This may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You moved into or out of NYC or Yonkers.
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn \$107,650 or more during the tax year.



230 N. Main Street, Spring Valley, NY 10977 Phone: (845) 363-8140 Fax: (845) 363-8141

Marquis now offers DIRECT DEPOSIT to all our employees. This option, if you decide to choose it, allows Marquis to deposit your weekly pay into your own personal savings or checking accounts. If you choose not to sign up for direct deposit you will be send a rapid pay card in the mail, with your money depostied on it.

We ask anyone who would like to participate in DIRECT DEPOSIT to fill in their account information below, detach and return slip to your local Marquis Office. Attach either a blank voided check or a savings deposit slip or BOTH if splitting deposit. You cannot have DIRECT DEPOSIT and receive a rapid pay card.

PRINT ALL INFORMATION

Direct Deposit Request (Don't forget to staple your voided check or filled in deposit slip for savings)

I authorize my employer/payer to initiate electronic credit entries and, if necessary, debit entries and adjustments for any credit entries made in error, to my financial institution list below:

FIRST NAME: _____ LAST NAME: _____
SS# _____

HOME ADDRESS: _____ APT. # _____

CITY: _____ STATE: _____ ZIP CODE: _____

BANK NAME: _____

BANK ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

ROUTING NUMBER _____ CHECKING ACCT# _____ DEPOSIT% _____

ROUTING NUMBER _____ SAVINGS ACCT# _____ DEPOSIT% _____

EMPLOYEE SIGNATURE: _____

DATE: _____

CDPAS APPLICATION

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

CDPAS Application

Phone: (845) 363-8140 Fax: (845) 262-2836

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 _____

HHA/PCA

Phone: (845) 363-8140 Fax: (845) 205-4296

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	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Night Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Unintentional weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Hoarseness	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Bloody Sputum	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you completed INH therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever had a BCG vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you had an x-ray while employed here?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee Signature

Date

Comments: _____

Agency Representative: _____ *Date* _____

HHA/PCA Application

Phone: (845) 363-8140 Fax: (845) 262-2836

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) 262-2836

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
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Drug	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems, Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emotional or Mental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Poor Vision	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
			Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
			Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Hernia	<input type="checkbox"/>	<input type="checkbox"/>
			Poor Hearing	<input type="checkbox"/>	<input type="checkbox"/>
			Allergies	<input type="checkbox"/>	<input type="checkbox"/>

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. _____

Employee Tuberculosis Skin Test Form

Phone: (845) 363-8140 Fax:(845) 262-2836

NAME: _____

DATE: _____ DOB: _____ Last four of SS # _____

PPD information to be completed by Medical provider or / RN Nurse only

Date PPD planted _____

Site:

- ☐ Right Arm
☐ Left Arm

Manufacturer _____ Lot# _____ Exp Date _____

Date PPD read _____ Result _____ mm ____ Neg ____ Pos

Name _____ Signature _____ ☐ MD ☐ RN

License _____

Stamp(If applicable)

Please complete and fax to 845-262-2836.
Thank you