CDPAS Application

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

Marquis Home Care PA Application

FOR APPLICANT TO COMPLETE:

Today's Date_______________

Name: ___________________________ Social Security #_______-_____-_______

Date of Birth: ______________ Country of Birth: ______________________

Street: ___________________________________ Apt #____________

City: ___________________ State: ___________ Zip Code: ____________________

Cell # ____________________________ Additional Phone # _______________________

Cell Phone Carrier ____________________ Email: __________________________________

Physician Name: ______________________ Primary Physician #________________________

Signature of Applicant__________________________________ **Date**______________

PA 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 the Company, 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 of Applicant **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/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.

WHAT IS ELECTRONIC VISIT VERIFICATION (EVV)?

Electronic Visit Verification, or EVV, is an electronic system that verifies when provider visits occur and captures the date and time of the visit, the location of the visit, the person who received the services, the person who provided the services, and the services provided. In most cases, a signature or voice verification from the individual receiving the services can also be captured.

The 21st Century Cures Act (the Cures Act) was signed into law on December 13, 2016, mandating that states implement Electronic Visit Verification (EVV) for all Medicaid-funded personal care services (PCS) and home health care services (HHCS) that require an in-home visit by a provider.

The following are the compliance deadlines established by the Cures Act:

• Personal Care Services – 1/1/2021

• Home Health Care Services – 1/1/2023

The goals of EVV are to ensure timely service delivery for members, including real-time service gap reporting and monitoring, reduce the administrative burden associated with paper timesheet processing and generate cost savings from the prevention of fraud, waste, and abuse. It aims to strengthen quality assurance by improving the health and welfare of individuals through validation of delivery of services.

The Cures Act requires that EVV systems capture the following six data points:

• Service type

• Individual receiving the service

• Date of service

• Location of service delivery

• Individual providing the services

• Begin and end times of service

WHO IS SUBJECT TO EVV?

The Cures Act requires that any Medicaid-funded personal care services (PCS) and home health care services (HHCS) that begin or end in the home be subject to EVV. Any provider billing Medicaid for personal care services that begin or end in the home for the following services, is subject to EVV:

- 1905(a)(24) State Plan Personal Care Benefit or Consumer Directed Personal Assistance (CDPA)
- Personal Care Assistance (PCA I & II)
- 1915(c) Home and Community Based Services waivers
- Children´s Waiver
- Nursing Home Transition and Diversion (NHTD) waiver
- Traumatic Brain Injury (TBI) waiver
- Office for People with Developmental Disabilities (OPWDD) comprehensive waiver
- 1115 Demonstration o CDPA
- PCA I & II

- EVV data is collected in a variety of methods including the Fingercheck app, patient's home phone or a FOB (a device that is placed in the patients home)
- All caregivers have been set up with a username and password for Fingercheck, as well as the number to call when using the patient's home phone, and have received instructions on what needs to be completed.
- In the event that a punch is missed and a manual punch is required to be entered by the coordinator, the below outlined process will be followed:

1. The coordinator will provide daily monitoring of call dashboards.
2. The coordinator will provide daily monitoring of Exception and Conflict reports. Conflicts will be investigated, resolved and documented according to the following guidelines:
   a. The coordinator will review the patient/employee calendar in the EMR in conjunction with the time sheet(s) and clock in(s) to determine if the patient was serviced by that employee on the date(s) in question.
   b. The coordinator will contact the appropriate representative at the other agency to determine when the aide in question worked for them. If no conflict exists, it will be documented as resolved in that quarter's corporate compliance log.

- When there is a live-in case, only one punch per day is required.
- If there are multiple caregivers in the home at the same time, each caregiver needs to have their own EVV record showing their clock in/out.
- If there are multiple clients in the same home receiving services, each client must have their own EVV record.
- Marquis Home Care will be submitting the required information into the state through our integrated platforms. There is nothing that needs to be done from the caregivers or patients in this regard.

I (name) ___________________________________ am a caregiver of Marquis Home Care and have read and fully understand the outlined requirements for proper EVV compliance. I am familiar with the resources that are available to me and understand that if I have any questions, I will reach out to Marquis Home Care.

Name (print): _______________________________________

Signature: ____

Date: ____

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):

☐ 1. A citizen of the United States

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

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): ____________

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

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

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

STOP *Employer Completes Next Page* STOP

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
1. U.S. Passport or U.S. Passport Card		**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		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**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		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**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. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (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.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
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		**6.** Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		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		

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
Under Section 195.1 of the New York State Labor Law
Notice for Exempt Employees

1. Employer Information

Name:
Marquis Home Care

Doing Business As (DBA) Name(s):

FEIN (optional):

Physical Address:

230 North Main Street, Spring Valley NY 10977

Mailing Address:

Phone:
845-363-8140

2. Notice given:

- ☒ At hiring
- ☐ Before a change in pay rate(s), allowances claimed, or payday

3. Employee's pay rate(s): State if pay is based on an hourly, salary, day rate, piece rate, or other basis.
Rockland- $13.00, Dutchess- $13.00, Orange - $13.00, Westchester/Suffolk- $14.82, 5 Boroughs- $16.69

____

Employers may not pay a non-hourly rate to a non-exempt employee in the Hospitality Industry, except for commissioned salespeople.

4. Allowances taken:

- ☒ None
- ☐ Tips _______per hour
- ☐ Meals ________per meal
- ☐ Lodging ______
- ☐ Other __________________

5. Regular payday: ________________

6. Pay is:

- ■ Weekly
- ☐ Bi-weekly
- ☐ Other: ________________

7. Overtime Pay Rate:
Most workers in NYS must receive at least 1½ times their regular rate of pay for all hours worked over 40 in a workweek, with few exceptions. A limited number of employees must only be paid overtime at 1½ times the minimum wage rate, or not at all.

____
This employee is exempt from overtime under the following exemption (optional):

8. Employee Acknowledgement:
On this day, I received notice of my pay rate, overtime rate (if eligible), allowances, and designated payday. I told my employer what my primary language is.

Check one:

☐ I have been given this pay notice in English because it is my primary language.

☐ My primary language is ___________. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

____
Print Employee Name

____
Employee Signature

____
Date

____
Preparer Name and Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

Please note: It is unlawful for an employee to be paid less than an employee of the opposite sex for equal work. Employers also may not prohibit employees from discussing wages with their co-workers.

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
Marquis Home Care

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/*Al contractar*
- ☐ 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, Dutchess- $13, Orange - $13, Westchester/Suffolk- $14.82, 5 Boroughs- $16.69 Albany $13.00**

per hour/*por horas*

4. Allowances taken /***Permisos tomados***

- ☐ None/*Ninguno*
- ☐ Tips/*Propinas*________ per hour/*por hora*
- ☐ Meals/*Almuerzo* ______ per meal/ porcomida
- ☐ 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)) :***

Esto debe ser al menos 1½ la tarifa regular del empleador, con pocas excepciones.

8. Employee Acknowledgement /***Reconocimiento delempleado*****:** 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*

Marquis Home Care
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/*Telefòn*:

2. Notice given/ *Yo bay avi a*:

- ☐ 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.*

LS 54HC (03/11)

3. Employee's Pay Rate/*To Pèyman Anplwaye a*: Rockland- $13.00, Dutchess- $13.00, Orange - $13.00, Westchester/Suffolk- $14.82, 5 Boroughs- $16.69

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 Siplemantè (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 siplemantè (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 dekole*

____
Employee Signature /*Siyati Anplwaye a*

____
Date/*Dat*

____
Preparer Name and Title /*Non ak Tit moun kap prepare dokiman 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.*

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2021

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | **(b) Social security number**

Address

City or town, state, and ZIP code

► **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*.

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

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

Department of Taxation and Finance

Employee's Withholding Allowance Certificate

IT-2104

New York State • New York City • Yonkers

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 ☐ Married ☐
		Married, but withhold at higher single rate ☐
City, village, or post office	State / ZIP code	**Note:** If married but legally separated, mark an ***X*** in the *Single or Head of household* box.

Are you a resident of New York City? .... Yes ☐ No ☐

Are you a resident of Yonkers? .... Yes ☐ No ☐

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 19)*	**1**	
2 Total number of allowances for New York City *(from line 31)*	**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

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

Instructions

Changes effective for 2021

Form IT-2104 has been revised for tax year 2021. 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 2021 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 did 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 federal and New York State 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 PA's. 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%** ________

PA SIGNATURE: ______________________________________ **DATE:** _____________________

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.

PA Signature: ________________________________ Date______________________

Name (Print):____

Agency Representative Signature_________________________ Date______________________

CDPAS Application

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

PA 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**

____ ___________________________

Applicant Signature ***Date***

Comments: ____

____

____

____

Agency Representative: ____ ***Date***_______________

CDPAS Application

Phone: (845) 363-8140 Fax: (845) &* &! &, ' *

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 year
2. Quantiferon results:
    - A Quantiferon should be performed within the year of hire. (Lab report showing your results, if you are negative/positive)

    ❖ If TB Testing 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

230 N. Main Street, Spring Valley, NY 10977 Phone: (845) 363-8162 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		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): ____

____

TB Risk Assessment

	YES	NO		YES	NO		YES	NO
Unexplained Fevers	[ ]	[ ]	Night Sweats	[ ]	[ ]	Cough	[ ]	[ ]
Unintentional Weight Loss	[ ]	[ ]	Hoarseness	[ ]	[ ]	Bloody sputum	[ ]	[ ]
Have you completed INH therapy?	[ ]	[ ]	Had a BCG vaccine?	[ ]	[ ]	Chest Xray while employed here	[ ]	[ ]

Was patient born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the middle East? ☐ Yes ☐ No

Did patient recently live or travel to Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the middle East for more then one month? ☐ Yes ☐ No

Was patient in close contact with someone who has had TB disease? ☐ Yes ☐ No

Does patient have immunosuppressed virus infection? ☐ Yes ☐ No

Does patient have current or planned immunosuppression, receipt of an organ transplant, treatment with a TNF-alpha antagonist, chronic steroids or other immunosuppressive medication; ☐ Yes ☐ No

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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: ___________________

IMMUNIZATION HISTORY

[ ] QuantiFERON: Collection Date _______________ Results __________________ (Attach original report)

For Positive PPD

[ ] 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 Test Form

Phone: (845) 363-8162 Fax: (845) 262-2836

NAME: ____

DATE:________________ DOB: _________________ Last four of SS # _______________

Quantiferon information to be completed by Medical provider

Quantiferon Blood Assay

Collection Date:_____________.

Report Date:________________.

Results_________

Print Name _______________________________ Signature__________________________

License _____________________________

Stamp(If applicable)

Please Attach Lab Report