VNS Caregivers Inc
Passionate Care for Seniors

Application for Employment

Personal Information (**Please** print) **Today's Date**:____/____/____

First Name:____ Last Name:____ Middle Initial:____

Street Address:____ Apt #:____ City:____ State:____ Zip Code: ____

Telephone: (Cell)____ (Email :)____

Are you legally eligible for employment in this country? YES OR NO. Date available for work:____/____/____

Emergency Contact Information

Name of Emergency Contact	Relation	Emergency Telephone Number

Employment Position Applying for:

☐ CNA ☐ PCA ☐ Homemaker ☐ Companion ☐ Other____

I understand that **I must** report all accidents, incidents, call outs, lateness to my immediate supervisor **and/or** to VNS CAREGIVERS INC - - No MATTER HOW SLIGHT. ☐ Yes

I also understand that I must wear all required scrubs or personal protection equipment (PPE). ☐ Yes
The penalty for not wearing scrubs or PPE is disciplinary action, up to and including termination.

Signature

If hired, would you have transportation to and from Work? YES OR NO:

Do you currently have a full-time job? YES OR NO. Do you smoke? YES OR NO.

Do you have allergies? YES OR NO. Can you work around dogs? YES OR NO. Cats? YES OR NO

Make and Year of Motor Vehicle Owned ____ Languages spoken apart from English ____

Do You have Insurance Coverage on your vehicle? YES OR NO

How many years of homecare experience do you have?____

Type of employment desired: ☐ Full Time ☐ Part Time ☐ Per Diem ☐ Temporary

Will you travel if the job requires it: ☐ No ☐ Yes .How many miles approximately____

Have you signed an agreement with a present or past employer not to work for a competitor or solicit business for a period of time?

☐ No ☐ Yes If yes, please provide details: ____

Computer Proficiency :(Check as appropriate). Word__Excel____Internet ..... Others____

EDUCATIONAL BACKGROUND	Name and Address of School	Circle Last Years Completed	Did You Graduate	Subjects Studied and Degrees Received
High School		1 2 3 4	☐ No ☐ Yes	
College		1 2 3 4	☐ No ☐ Yes	
Post College		1 2 3 4	☐ No ☐ Yes	

List skills relevant to the position applied for: ____

EMPLOYMENT HISTORY

Provide the following information for your past and current employers, assignments or volunteer activities, starting with the most recent. Please complete even if you have an attached resume.

Years	Company Name Address / Phone	Position Held	Supervisor's Name, Title and Phone Number	Reason for Leaving	Salary or Hourly
/ / to / /					$ to $
/ / to / /					$ to $

REFERENCES:

List three professional references who are not related to you, which you have known at least one year.

Name / Company / Job Title	Telephone Number	# Years Known
1.		
2.		
3.		

If selected for employment, are you willing to submit to pre-employment background checks? YES OR NO
If No, please explain here:_____

Have you ever lived in any other state(s) apart from Connecticut in the last Seven (7) years? If yes list them here_____

I understand and agree that:

- The information that I have provided on this application is true and complete to the best of my knowledge. Any misrepresentation or omission of any fact in my application, resume, or any other materials, or during any interviews, can be justification for refusal of employment, or, if employed, termination from the Company.
- I give the employer the right to contact and obtain information from all references, employers, and educational institutions and to otherwise verify the accuracy of the information contained in this application. I hereby release from liability the employer and its representatives for seeking, gathering, and using such information and all other persons, corporations, or organizations from furnishing such information.
- If I am hired, I understand that I am free to resign at any time, with or without cause and without prior notice, and the company reserves the same right to terminate my employment at any time, with or without cause and without prior notice, except as may be required by law. This application does not constitute an agreement or contract for employment for any specified period or definite duration. I understand that no representative of the employer, other than an authorized officer, has the authority to make any assurances to the contrary. I further understand that any such assurances must be in writing and signed by an authorized officer. I understand that if I receive an offer of employment and I accept the position, I will be on probation for 90 days and I will be required to complete additional information necessary for company record keeping requirements.
- This application is current for only 90 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 for me to fill out a new application.
- I understand it is this Company's policy not to refuse to hire a qualified individual with a disability because of that person's need for a reasonable accommodation unless doing so is an undue hardship for the Company.
- I promise, prior to leaving employment, to return all timesheets, keys, ID cards, materials, equipment, and any other property of the Company.

I represent that I have read and fully understand the foregoing and seek employment under these conditions.

Signature of Applicant:_____ Date: _____

YOUR AVAILABILITY

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							
Overnight							
Live-In							

Are you willing to provide back up or additional hours in the case of an emergency? Yes_____No_____

Please List the Towns or Locations in which you prefer clients:

_____

_____

SELF ASSESSMENT SUMMARY (circle as applicable)

Please rate your level of experience (1=No experience 2=Some experience 3=Experienced 4=Very experienced)

Personal Care

Bathing a client in tub	1 2 3 4
Bathing a client in shower	1 2 3 4
Sponge bathing client	1 2 3 4
Washing a client's hair	1 2 3 4
Applying lotion to client's skin	1 2 3 4
Brushing a client's teeth	1 2 3 4
Assisting with toileting	1 2 3 4
Using a bed pan	1 2 3 4
Changing client's briefs/diaper	1 2 3 4
Assist client with dressing	1 2 3 4
Dress client	1 2 3 4
Assist client with other grooming	1 2 3 4
Operate a hospital bed	1 2 3 4
Transferring a client	1 2 3 4
Positioning/Turning a client	1 2 3 4
Using a gait belt	1 2 3 4
Lifting a client	1 2 3 4

Ambulation & Transferring

Assist into/out of automobile	1 2 3 4
Assisting client with walking	1 2 3 4
Assisting client with cane	1 2 3 4
Assisting client with walker	1 2 3 4
Assisting client with wheelchair	1 2 3 4

Transportation

Driving client in their car	1 2 3 4
Running Errands	1 2 3 4
Escorting to appointments	1 2 3 4

Meals

Shopping for food	1 2 3 4
Cooking	1 2 3 4
Meal preparation	1 2 3 4
Feeding client	1 2 3 4

Light Housekeeping

Changing bed linens	1 2 3 4
Vacuuming	1 2 3 4
Cleaning restrooms/kitchen	1 2 3 4
Laundry	1 2 3 4

Specific Conditions

Dementia/Alzheimer's	1 2 3 4
Parkinson's	1 2 3 4
Hospice/End of Life Care	1 2 3 4
Stroke	1 2 3 4
Cancer/Chemotherapy	1 2 3 4
Mental Illness	1 2 3 4
Paralyzed	1 2 3 4
Broken hip or replacement	1 2 3 4

VNS CAREGIVERS INC

AUTHORIZATION FOR DIRECT DEPOSIT

(Please attach a voided check for each bank account to which funds should be deposited.)

I _____ authorize ***VNS CAREGIVERS INC*** to deposit my pay automatically to the account(s) indicated below and, if necessary, to adjust or reverse a direct deposit for any payroll entry made to my account in error. This authorization will remain in effect until I cancel it in writing and in such time as to afford ***VNS CAREGIVERS INC*** a reasonable opportunity to act on it.

Birth Date: MM_____/DD_____/YY_____ Hire Date: MM_____/DD_____/YY_____

Social Security Number: _____Gender: Female: _____Male: _____

Email Address: _____Telephone: _____

PRIMARY DIRECT DEPOSIT

Name of Bank: _____

Bank Account Number: _____

Bank Account Routing Number: _____

D Checking D Savings D Amount:$_____ or D Entire Paycheck

*Balance of pay to: D Secondary account described below

*Note: Split payments are not available for contractors.

SECONDARY DIRECT DEPOSIT (balance after direct deposit entry above)

Name of Bank: _____

Bank Account Number: _____

Bank Account Routing Number: _____

D Checking D Savings D Amount:$_____ or D Entire Paycheck

PAY FREQUENCY IS EVERY OTHER WEEK ON FRIDAYS.

Employee/Contractor Signature: _____ Date: _____

VNS CAREGIVERS INC

"Passionate Care for Seniors & Others."

NEW HIRE ORIENTATION CHECKLIST

Name: _____ **Date** _____

THE FOLLOWING TOPICS ARE INCLUDED IN OUR EMPLOYEE MANUAL &PRESENTED IN NEW HIRE ORIENTATION.

- Welcome (Mission, Goals, Philosophy)
- Employment Relationship
- Workplace Guidelines & Expectations
- Policies & Procedures
- Workplace Safety
- Employee Benefits
- Handouts/Forms

THE FOLLOWING FORMS MUST BE READ AND ACKNOWLEDGED BY SIGNATURE FOR EMPLOYMENT.

- Handbook Acknowledgement & Receipt
- TB Questionnaire
- Medical Waiver/Election
- Caregiver Commitment Agreement
- State of Loss/Damage/Theft
- Acknowledgement of Job Description/Rates
- Hep B Waiver/Request
- Photo, Video & Audio Recordings
- Driver/Non-Driver Form
- New Hire Orientation Checklist

THE FOLLOWING ASSIGNMENTS MUSTBE COMPLETED PRIORTO CASE ASSIGNMENT AND EMPLOYMENT.

- PCA Curriculum Courses/Skills
- Medical/Health Certificate
- Sandata Mobile Connect Training
- ABI AND RA
- Sexual Harassment (2-hour CHRO Course)
- Timesheet/Clock in-out/Incident Reporting

IACKNOWLEDGE THAT IWAS GIVEN THE FOLLOWING HANDOUTS IN MY EMPLOYEE MANUAL PACKET.

- Employee Benefits
- Emergency Preparedness
- Elder Abuse
- Sandata/Santrax (Clocking In/Out)
- Training Packet
- FMLA
- Sexual Harassment
- Newsletters

I have reviewed the checklist above and have had the opportunity to ask questions regarding the Employee Manual and New Hire Orientation. I understand and agree to the information presented to me and will abide by VNS Caregivers Inc. policies and procedures and any changes or updates for employment VNS Caregivers Inc. I further understand that if I violate any policy and/or procedure I will be subject to disciplinary action which may include termination of employment or other repercussions.

Employee Signature: _____

VNS CAREGIVERS INC

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CONFIDENTIALITY AGREEMENT

Our clients and other parties with whom we do business entrust the company with important information relating to their businesses. It is our policy that all information considered confidential will not be disclosed to external parties or to employees without a "need to know." If an employee questions whether certain information is considered confidential, he/she should first check with his/her immediate supervisor.

This policy is intended to alert employees to the need for discretion at all times and is not intended to inhibit normal business communications.

All inquiries from the media must be referred to the Head Office.

Employees and volunteers of *VNS Caregivers Inc* are bound by ethical and legal codes to protect the confidentiality and privacy of our clients, co-workers and others associated with *VNS Caregivers Inc* and to protect and maintain the confidentiality of all information learned about, but not limited to clients, their family members, and acquaintances in the course of providing services to them and/or information learned and/or acquired during your employment at *VNS Caregivers Inc*.

Confidential communications include conversations, reports, forms, correspondence, photos, videos, audio recordings, and computer-generated communications, (either verbal, in writing or electronically) with, about or involving in any way any client of *VNS Caregivers Inc* or other information deemed confidential.

I understand and agree to the statements above and will abide in its entirety even if my employment at *VNS Caregivers Inc* has terminated. I further understand that if I violate this agreement policy I will be subject to disciplinary action which may include termination of employment or other repercussions.

Employee Name: _____ Date: _____

Employee Signature: _____

VNS CAREGIVERS INC

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Conflicts of Interest and Non-Compete Disclosure Acknowledgement

Employees, volunteers, interns and contracted staff must avoid any relationship or activity that might impair, or even appear to impair, their ability to make objective and fair decisions when performing their jobs.

At times, you may be faced with situations in which business actions taken on behalf of VNS Caregivers Inc. may conflict with your own personal interests. VNS Caregivers Inc has the responsibility to ensure that all employees, volunteers, interns and contracted staff engage in activities that are consistent with our mission, goals and philosophy in delivering programs and services.

All employees, volunteers, interns and contracted staff must perform their job duties to the best of their ability. In situations in which you are engaged in activities that could constitute a conflict of interest, VNS Caregivers Inc has the responsibility to review each situation and determine whether a conflict exists. The following situations require a review and determination by the assigned appointing authority:

You may not . . .

- Act as a consultant to a competitor or potential competitor, supplier or contractor, regardless of the nature of the employment, while employed with VNS Caregivers Inc.
- Hiring or supervising family members or closely related persons.
- Serving as a hiring employee for a competitor company or related business.
- Owning or having a substantial interest in a competitor, or contractor.
- Accepting gifts, discounts, favors or services from an existing client/customer, potential client/customer or competitor business, unless equally available to all company employees.
- Use your position to gain favors or other personal consideration,
- Grant favors or unwarranted benefits.
- Establish personal relationships with clients, family members for whom you provide services.
- Service clients who are family members.
- Service clients on a private basis or for private pay for additional hours under any circumstance.
- Receive compensation from public or private agencies, businesses, individuals, organizations, or other groups, without approval from Administration.
- Use agency equipment or copyrighted publications obtained with VNS Caregivers Inc funds for outside employment-related activities.
- Work for compensation outside your regular VNS Caregivers Inc employment when the outside work does not interfere with their ability to perform their VNS Caregivers Inc job duties. Interfere with or reflect negatively on the work performed by VNS Caregivers Inc. Involve any unethical practices that would impact their ability to perform their VNS Caregivers Inc job duties.

You may not accept gifts related to the performance of your job duties. If you are offered gifts, gratuities, or favors related to the performance of your job duties you shall report the offers to the Human Resources department.

You may not solicit or accept gifts of monetary value from clients, client family members/friends, members of the public, or vendors/contractors as a result of being employed by VNS Caregivers Inc You may not solicit or accept gifts that imply forgiveness of a debt or creating an expectation of special service or benefits to your job duties relating to VNS Caregivers Inc.

You shall not solicit or accept gifts that would generate income or revenue for clients or family members/friends.

You shall request approval from the Human Resources department before accepting gifts that customarily would be viewed as a courteous gesture of thanks, as signs of appreciation, or as reward for service or performance.

You may not sell, buy, trade, negotiate, or accept any services or items from clients or client's family members/friends except when doing so is in accordance with the client's treatment or service plans.

You may not use information about clients that was gained during employment with VNS Caregivers Inc to further the staff member's personal gain.

Company property, information or business opportunities may not be used for personal gain.

You may not knowingly conduct or negotiate business matters with former or discharged clients for 12 months from the date of discharge. This includes referring them to other agencies while an employee with VNS Caregivers Inc Agency.

Employees with a conflict-of-interest question should seek advice from management. Before engaging in any activity, transaction or relationship that might give rise to a conflict of interest, employees must seek review from the Human Resource department.

D I hereby affirm that I know of no issues that would present a conflict of interest arising from any situation related to my involvement/association with VNS CAREGIVERS INC Agency.

D I may have a conflict arising from the following situation: _____

_____*Describe the potential conflict, including both the other entity in which you have an interest and the dealings it has with VNS CAREGIVERS INC Agency and the appropriate date(s) the conflict arose.)*

I understand that the Conflict of Interest and Non-Compete Agreement prohibits my involvement in transactions in which I have conflict or otherwise violate this agreement. Therefore, in any instance in which I may be required to participate in a situation impacted by such conflict, I will notify the Administrator and/or Credentialing and Compliance Director and Human Resources of the conflict of interest and will abide by the resultant decision.

Employee Name: _____ Date: _____

Employee Signature: _____

VNS CAREGIVERS INC

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EMPLOYEE ACKNOWLEDGEMENT & RECEIPT OF HANDBOOK

I understand and agree that nothing in the Employee Handbook creates, or is intended to create, a promise or representation of continued employment and that employment at VNS CAREGIVERS INC Agency is employment at will, which may be terminated at the will of either VNS CAREGIVERS INC Agency or myself. Furthermore, I acknowledge that this handbook is neither a contract of employment nor a legal document. I understand and agree that employment and compensation may be terminated with or without cause at any time by VNS CAREGIVERS INC Agency or myself.

(THE FOLLOWING STATEMENTS REQUIRE ACKNOWLEDGEMENT BY INITIALING AND SIGNING BELOW.)

_____ **CONFIDENTIALITY:** I understand that I am bound by ethical and legal codes to protect the confidentiality and privacy (either verbal, in writing, electronically, photos, videos & recordings) of our clients, co-workers and others associated with *VNS Caregivers Inc* and to protect and maintain the confidentiality of all information learned about, but not limited to clients, their family members and acquaintances in the course of providing services to them and/or information learned and/or acquired during my employment at *VNS Caregivers Inc*.

_____ **WORKER'S COMPENSATION:** I understand that in the event of a work-related injury or death, I am covered by The Workplace Safety & Insurance Board (WSIB) and must report incidents immediately or earliest time **but within 24 hours**.

_____ **ELECTRONIC TIME KEEPING PROCEDURES: (Santrax/Sandata EVV and/or Open timeclock:** It is mandatory that all employees clock in/out for each shift using either Santrax EVV System, or open time clock. I understand that the falsification of documents, particularly those pertaining to the submission of visit notes/times where in fact no visit was made or failure to report accurate times, is considered fraud and is subject to disciplinary action or termination and civil and/or criminal prosecution per state and federal laws.

_____ **CONFLICT OF INTEREST/NON-COMPETE:** I understand I must avoid any relationship or activity that might impair, or even appear to impair, their ability to make objective and fair decisions when performing my job. Any situation that may conflict or compete with VNS CAREGIVERS INC Agency must be reported to Human Resources.

_____ **PHOTOS, VIDEOS & AUDIO RECORDINGS:** VNS CAREGIVERS INC Agency holds a zero-tolerance for the misuse of photos, videos and audio recordings of any of its clients, employees, visitors and other associated with VNS CAREGIVERS INC other than for the purpose or treatment and reporting. Posting and/or sending of any form of media on social media platforms are strictly forbidden and will be subject to immediate termination and subject to state and federal laws as applicable.

_____ **SEXUAL HARASSMENT PREVENTION COMMITMENT:** Harassment in any form, sexual, hostile environment and bullying is prohibited and have severe consequences. I am committed to supporting a safe environment and will report actions and behaviors that violate the policy and/or endanger individuals.

I have received the handbook and have had an opportunity to ask questions. I understand that it is my responsibility to read and comply with the policies contained in this handbook and any revisions to it.

Employee Name: _____ Date: _____

Employee Signature: _____

VNS CAREGIVERS INC

"Passionate Care for Seniors & Others."

My commitment to VNS CAREGIVERS INC as a Caregiver/Office Staff

I will not . . .

1. Use the client's personal property without the client's consent including telephone for personal calls.
2. Consume the client's food and beverages.
3. Forge client's signature or falsify documentation.
4. Bring friends, relatives, pets or any unauthorized individual to the client's home.
5. Transport client away from home (unless authorized) or take the client to my place of residence (home).
6. Breach client's privacy or divulge client information.
7. Consume alcoholic beverages, medicine, drugs, or other chemical substances not in accordance with the legal, valid, prescribed use and/or in any way that impairs my delivery of services to the client while in the client's home or prior to the service delivery.
8. Smoke in the client's home.
9. Watch TV, computer, play video games or sit around and chat unless authorized by service specifications.
10. Steal, borrow, accept, obtain or attempt to obtain money or anything of value, including gifts or tips from the client, household members and family members of the client or caregiver.
11. Discuss personal problems, religious or political beliefs with the client and others in the care setting.
12. Engage in non-care related socialization with individuals other than the client.
13. Provide care to individuals other than the client.
14. Sleep at the client's residence (unless as authorized per live-in shift work).
15. Engage in sexual conduct or in conduct that may reasonably be interpreted as sexual in nature, regardless of whether the contact is consensual with the client or not.
16. Engage in behavior that may reasonably be interpreted as inappropriate involvement in the client's personal relationships.
17. Engage in behavior that causes or may cause physical, verbal, mental or emotional distress or abuse to the client.
18. Be designated to make decisions for the client in any capacity involving a declaration for mental health treatment, power of attorney, durable power of attorney, or guardianship.
19. Sell or purchase from the client products or personal items. The only exception to this prohibition occurs when the client is a family member and the provider is not delivering services.
20. Engage in behavior that constitutes a conflict of interest or takes advantage of or manipulates services contracted by VNS CAREGIVERS INC, resulting in an unintended advantage for personal gain that has detrimental results for the client, the client's family or caregivers, or another provider.
21. Leave the home for a purpose not related to the provision of services without notifying the agency supervisor, the client's emergency contact person, any identified caregiver, and/or the client's care manager, or for client-directed services providers, leave the home without the consent and/or knowledge of the client.
22. Extend the relationship with the client beyond the specific service dates and/or boundaries that have been established by the applicable service specification(s).
23. Engage in a disagreement with the client but will, instead seek to improve communication and express willingness to work together constructively. In the event of a disagreement contact the Care Manger immediately. A disagreement is a failure or refusal to agree which may escalate into a conflict or quarrel.
24. Deny service to a client due to the client's living conductions including pest, health, behavior (including toughing) or language. VNS CAREGIVERS INC does not make the distinction between behavior and language that are the result of a condition verses someone who consistently displays inappropriate, intolerable behavior/ language or threatening behavior/language. Providers must comply with OSHA standards and the Fair Labor Standard Act for employees. Also applies to language other than English.

Name: _____ Signature: _____ Date: _____

VNS CAREGIVERS INC

"Passionate Care for Seniors & Others."

TB SURVEILLANCE QUESTIONNAIRE FOR HEALTHCARE WORKERS

Name: _____ Date: _____

Employer: **VNS CAREGIVERS INC** Job Title: _____

Tuberculosis (also known as TB) is a bacterial infection that can cause pneumonia, fever, and weight loss, and may involve other systems of the body. Some people who acquire the disease are very ill. Others have very few symptoms. It is transmitted through the air from person to person. Incidence in the U.S. has been increasing in recent years. Control of the disease is based on early detection as well as treatment of exposed people with antibiotics. Skin tests such as PPD (purified Protein Derivative) may aid in the early diagnosis of exposure to TB.

The questions below must be answered prior to the administration of PPD test.

1. Have you ever had Tuberculosis? Yes No

2. Have you ever had a close contact with someone who has TB? (Such as family member, co-worker, or patient in your care.) If yes, please give details. Yes No
   _____

3. Have you ever received BCG (Bacillus Callmette-Guerin vaccine)? This is a vaccine against TB, usually given outside the U.S. Yes No

4. Have you recently traveled to a foreign country where TB is common? If yes, please give details: _____ Yes No

5. Are you currently, or have you recently been treated with steroids, or other medications that suppress the immune system? Yes No

6. Are you currently, or have you in the past, experienced any of the following symptoms . . . weight loss, bloody sputum, persistent fever, severe cough, loss of appetite, night sweats? Yes No

7. Have you ever had a positive skin test for TB? If yes, give details: _____ Yes No

8. Were you born in the United States? If no, in what country were you born? _____ Yes No

Employee Signature: _____

VNS Caregivers Inc. 30 Hazel Terrace, Suite 8, Woodbridge, CT 06525, Tel: 203-298-4867 * Fax: 203-404-3109

VNS CAREGIVERS INC

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HEPATITIS B VACCINE ACCEPTANCE/DECLINATION

Employee Name: _____ DOB: _____

In understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B Vaccine at no charge to me.

I have decided to . . .

- Request that I receive the Hepatitis B vaccine.
- Decline the vaccination at this time due to: _____
- Titre evidence immunity.
- Previous Hepatitis B vaccination on: _____
- Medical contraindications. Contraindications include: Pregnancy, active infection such as cold or bronchitis, lactation, or allergy to yeast or yeast products. I understand that by declining the vaccine, I continue to be at risk of acquiring Hepatitis B Virus (HBV) infection. If in the future, I continue to have occupational exposure to bold or any other potentially infectious materials, and I want to be vaccinated with the Hepatitis B vaccine, I will consult my physician and obtain written approval before receiving the Hepatitis B vaccine. I understand that I can then obtain the Hepatitis B vaccine at no charge to me.
- Decline vaccination for other personal reasons. I understand that by declining the vaccine, I continue to be at risk of acquiring Hepatitis B Virus (HBV) infection. If in the future, I continue to have occupational exposure to bold or any other potentially infectious materials, and I want to be vaccinated with the Hepatitis B vaccine, I understand that I can then obtain the Hepatitis B vaccine at no charge to me.

_____ _____

Employee Signature Date

_____

VNS Caregivers Inc Representative

VNS CAREGIVERS INC

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DRIVER/NON-DRIVER ACKNOWLEDGEMNT

- As an employee of VNS CAREGIVERS INC Agency, I declare that my vehicle is in good/safe working order and that as a driver my driver's license is active and valid. I must keep active and valid the following at all times and provide copies to Human Resources for record:
    - Driver's License
    - Auto Insurance (at least the minimum coverage as required by the State of Connecticut)
    - Auto Registration

- As an employee of VNS CAREGIVERS INC Agency, I affirm that I will not driving for any work related activities whether paid or unpaid and will not have any clients or employees or any one in connection to VNS CAREGIVERS INC Agency in my vehicle at any time. ***I understand that false information or misrepresentation in regard to this statement may have employment and/or legal consequences***.

If at any point my driver status, auto insurance or vehicle registration has changed due to new driver, suspension, revocation, change in vehicle or other situation which will prevent me from legally driving the vehicle, I understand that it is my responsibility to notify human resources so that my driver status may be updated to avoid adverse incidents.

Once my status has changed to valid and active with the Department of Motor Vehicles, I will forward supporting documentation to human resources so that I may be reinstated to driver status.

I agree to abide by all driver procedures when driving with a client as sated below:

- Use seat belts or other available occupant restraints and require all occupants to use seat belts or occupant restraints, in accordance with state laws and not operate the vehicle unless all occupants are wearing the appropriate restraints.
- Never permit total occupancy to exceed the number of seat belts.
- Use safe driving principles, practices and techniques in accordance with driver training/testing.
- Not drive under the influence of drugs or alcohol.
- Not drive if using a medication that impairs judgment, reflexes or alertness.
- Not drive the vehicle at speeds that are inappropriate for road conditions or exceed the posted speed limit.
- Not text and drive or use any mobile devises or any other device when the vehicle is moving or engage in other distracting behavior. If using a cell phone, it must be "hands-free".
- The vehicle must be safely stopped and secured (parked), if not using "hands-free" devices
- I understand that it is at my cost and responsibility if I incur and traffic violations or parking tickets.

I understand, acknowledge and agree to comply with all statements and procedures. I further certify that all information provided to the VNS CAREGIVERS INC Agency are true and accurate and to the best of my knowledge the vehicle I am using is in good working and safe order.

Employee Name (Printed): _____

Employee Signature: _____ Date Signed: _____

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DAMAGE/LOSS/THEFT ACKNOWLEDGMENT

VNS CAREGIVERS INC Agency holds a zero-tolerance **policy** for **theft,** damage, and dishonesty. Any investigation leading to the confirmation of **theft, damage** or dishonesty of any employee will result in the immediate termination of that employee.

VNS CAREGIVERS INC Agency recognizes that despite all efforts being taken to minimize instances of accidental damage and/or theft to equipment, belongings, or property; events may still occur during service provision to clients.

VNS CAREGIVERS INC Agency does not accept responsibility for accidental damage to client property during the provision of service

This policy creates no legal obligation on the part of VNS CAREGIVERS INC Agency to reimburse any individual or entity for damages or theft of property.

This policy statement is applicable to all clients and employees of VNS CAREGIVERS INC Agency.

VNS CAREGIVERS INC Agency is committed to providing a framework for investigating and responding to instances of accidental damage and theft.

Under no circumstances should the Employee admit liability or make offers of reimbursement on behalf of VNS CAREGIVERS INC Agency. The Client or their representative will be advised that VNS CAREGIVERS INC Agency will investigate the instance and provide them with a response

If VNS CAREGIVERS INC Agency determines that the cause of the damage/theft was accidental, i.e. that the Employee:

- Was appropriately briefed regarding the task.
- Was provided with the appropriate equipment to complete the task.
- Acted in accordance with the requirements of the service provision.

VNS CAREGIVERS INC Agency does not accept responsibility for accidental damage/theft and the Client will be advised to utilize their insurance or own means to repair/replace the damaged item.

Negligence on Behalf of the Employee

In the unlikely event that VNS CAREGIVERS INC Agency has determined the cause of the damage was as a result of negligence on behalf of the Employee, i.e. that the Employee:

- Had deliberately or willfully caused damage.
- Had ignored an instruction given to them regarding how to complete a task, including details specified in the Client's Service Plan.
- Had used equipment incorrectly or breached a safeguard put in place to minimize the likelihood of damage occurring.

VNS CAREGIVERS INC

"Passionate Care for Seniors & Others."

In this instance VNS CAREGIVERS INC Agency will consider all information relating to the damage/loss/theft and will advise the client to initiate their insurance process. Consideration may be made on a case by case basis regarding any reimbursement for damage/theft or loss to the extent that any insurance proceeds are not sufficient to reimburse the damage or loss. Matters of Employee performance management and any relevant disciplinary actions as a result of the event will be managed in accordance with VNS CAREGIVERS INC Agency Human Resource policies.

Wear and Tear

VNS CAREGIVERS INC Agency makes no reimbursement for damage caused through the wear and tear of items, even if the damage occurs at the time that the Employee was using the item.

I understand that . . .

- Efforts will be made to ensure the client is fully informed of the procedures throughout any investigation.
- Consideration will be made in relation to the specific situations for each reported event and due deliberation applied.
- The incident will be managed in a way that recognizes the distress and inconvenience experienced by all parties.
- Reported instance of accidental damage, loss or theft by a Client, their representative, or the Case Manager will initiate an investigation. Investigations ensure the following are obtained:
- Report/Statement from the Client/their representative.
- Report/Statement from the employee(s) involved.
- The Client/their representative advise plan for having the damaged/theft item repaired or replaced.
- Statement from the Case Worker regarding what item was damaged/theft and how this occurred.
- If an employee causes damage or loss because of poor performance, the employee will be subject to disciplinary action up to and including termination.
- Willful or intentional misuse, damage, loss or theft of company, client property resulting in significant loss could be grounds for immediate termination.
- Employers and clients can file a civil suit or make a claim in small claims court to recoup the money owed for the loss or damage or stolen property/item.
- By signing this statement, I am acknowledging that I understand, I have had the opportunity to ask questions and accept and will abide by the terms of this policy.

_____ _____

Printed Employee Name Date

_____

Employee Signature

Attendance Policy

Objective

The purpose of this policy is to set forth VNS Caregivers Inc.'s policy and procedures for handling employee absences and tardiness to promote the efficient operation of the company and minimize unscheduled absences.

Policy

Punctual and regular attendance is an essential responsibility of each employee at VNS Caregivers Inc. Employees are expected to report to work as scheduled, on time and prepared to start working. Employees also are expected to remain at work for their entire work schedule. Late arrival, early departure or other absences from scheduled hours are disruptive and must be avoided.

This policy does not apply to absences covered by the Family and Medical Leave Act (FMLA) or leave provided as a reasonable accommodation under the Americans with Disabilities Act (ADA). These exceptions are described in separate policies.

Absence

"Absence" is defined as the failure of an employee to report for work when he or she is scheduled to work. The two types of absences are defined below:

- *Excused absence* occurs when all the following conditions are met:
    - The employee provides to his or her supervisor sufficient notice at least 48 hours in advance of the absence.
    - The absence request is approved in advance by the employee's supervisor.

- *Unexcused absence* occurs when any of the above conditions are not met. If it is necessary for an employee to be absent or late for work because of an illness or an emergency, the employee must notify his or her supervisor no later than the employee's scheduled starting time on that same day. If the employee is unable to call, he or she must have someone make the call.

An unexcused absence counts as one occurrence for the purposes of discipline under this policy.

Employees with three or more consecutive days of excused absences *because of illness or injury* must give VNS Caregivers Inc. proof of physician's care and a fitness for duty release prior to returning to work.

Name_____

Signature_____

Date_____

Tardiness and Early Departures

Employees are expected to report to work and return from scheduled breaks on time. If employees cannot report to work as scheduled, they must notify their supervisor no later than their regular starting time. This notification does not excuse the tardiness but simply notifies the supervisor that a schedule change may be necessary.

Employees who must leave work before the end of their scheduled shift must notify a supervisor immediately.

Tardiness and early departures are each one-half an occurrence for the purpose of discipline under this policy.

Disciplinary Action

Excessive absenteeism is defined as two or more occurrences of unexcused absence in a 30-day period and will result in disciplinary action. Three (3) occurrences of unexcused absence or instance in a 12-month period are considered grounds for termination.

Job Abandonment / Voluntary Quit

Any employee who fails to report to work in a three or more instances in a 12 month period or been absent from work for a 30 days period without notifying his or her supervisor will be considered to have abandoned the job and voluntarily terminated the employment relationship.

Name_____

Signature_____

Date_____

VNS Caregivers Inc
30 Hazel Terrace Suite 8 Woodbridge CT 06525.
"Passionate Care for Seniors & Others"

Tel:203-298-4867
Fax: 203-404-3109
www.vnscaregivers.com

HEALTH CERTIFICATE

In order to protect the health and welfare of our employees and those with whom they have contact at work, *VNS Caregivers Inc* reserves the right to condition employment upon receipt of a satisfactory statement of a licensed physician.

Whenever an employee suffers an illness, injury or disability, the employee may be asked to provide a physician's statement that verifies the nature of an illness, injury, injury or disability, beginning and ending dates, the employee's ability to work, and any associated health risk to the employee, co-worker or others. All medical data provided including this physician's verification is confidential and shall be accessed only when necessary to determine matters relevant to the placement and/or continued employment of the employee.

Employee Name: _____ DOB_____

Date PPD Placed: _____ Date Read: _____

Result of TB Test: ___ Negative _ Positive Size_ _ _ _ _

Date of Chest X-Ray: _____-... _ Negative Positive

Describe any limitations

Or

Restrictions_____

The individual listed above is physically and mentally qualified to perform the duties to be assigned and has no health condition that would create a hazard to patients. The individual is *free of communicable disease.* Furthermore, the individual has no limitations and is able to perform the required job functions.

_____ _____

Physician signature Date

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

2026

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) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **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.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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, and when to use the estimator at *www.irs.gov/W4App*.

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 the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **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 generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . . ☐

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 Dependent and Other Credits

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

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

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

Exempt from withholding: I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

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 Revenue Services
State of Connecticut

(Rev. 12/25)

Form CT-W4
Employee's Withholding Certificate

Effective January 1, 2026

Employee Instructions

- Read the instructions on Page 2 before completing this form.
- Select the filing status you expect to report on your Connecticut income tax return.

Choose the statement that best describes your gross income.

- Enter the *Withholding Code* on Line 1 below.

Married Filing Jointly	Withholding Code
Our expected combined annual gross income is **less** than or equal to $24,000 or I am claiming exemption under the Military Spouses Residency Relief Act (MSRRA)* and no withholding is necessary.	**E**
My spouse **is** employed and our expected combined annual gross income is **greater** than $24,000 and less than or equal to $100,500. See *Certain Married Individuals,* Page 2.	**A**
My spouse **is not** employed and our expected combined annual gross income is **greater** than $24,000.	**C**
My spouse **is** employed and our expected combined annual gross income is **greater** than $100,500.	**D**
I have significant nonwage income and wish to avoid having too little tax withheld.	**D**
I am a nonresident of Connecticut with substantial other income.	**D**
Qualifying Surviving Spouse	**Withholding Code**
My expected annual gross income is **less** than or equal to $24,000 or I am claiming exemption under the MSRRA* and no withholding is necessary.	**E**
My expected annual gross income is **greater** than $24,000.	**C**
I have significant nonwage income and wish to avoid having too little tax withheld.	**D**
I am a nonresident of Connecticut with substantial other income.	**D**

Married Filing Separately	Withholding Code
My expected annual gross income is **less** than or equal to $12,000 or I am claiming exemption under the MSRRA* and no withholding is necessary.	**E**
My expected annual gross income is **greater** than $12,000.	**A**
I have significant nonwage income and wish to avoid having too little tax withheld.	**D**
I am a nonresident of Connecticut with substantial other income.	**D**
Single	**Withholding Code**
My expected annual gross income is **less** than or equal to $15,000 and no withholding is necessary.	**E**
My expected annual gross income is **greater** than $15,000.	**F**
I have significant nonwage income and wish to avoid having too little tax withheld.	**D**
I am a nonresident of Connecticut with substantial other income.	**D**
Head of Household	**Withholding Code**
My expected annual gross income is **less** than or equal to $19,000 and no withholding is necessary.	**E**
My expected annual gross income is **greater** than $19,000.	**B**
I have significant nonwage income and wish to avoid having too little tax withheld.	**D**
I am a nonresident of Connecticut with substantial other income.	**D**

* If you are claiming the Military Spouses Residency Relief Act (MSRRA) exemption, see instructions on Page 2.

Employees: See *Employee General Instructions* on Page 2. Sign and return Form CT-W4 to your employer. Keep a copy for your records.

1. Withholding Code: Enter *Withholding Code* letter chosen from above ..... 1. _____

2. Additional withholding amount per pay period: If any, see instructions.....2. $

3. Reduced withholding amount per pay period: If any, see instructions ..... 3. $_____

Check if you are claiming the MSRRA exemption and enter state of legal residence/domicile: _____

First name	MI	Last name	Social Security Number
Home address (number and street, apartment number, suite number, PO Box)			
City/town	State	ZIP code	

Declaration: I declare under penalty of law that I have examined this certificate and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for reporting false information is a fine of not more than $5,000, imprisonment for not more than five years, or both.

Employee's signature | Date

Employers: See *Employer Instructions,* on Page 2.

Is this a new or rehired employee? **No** Yes Enter date hired: _____ mm/dd/yyyy

Employer's business name			Federal Employer Identification Number
Employer's business address			
City/town	State	ZIP code	
Contact person			Telephone number

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. An alien authorized to work until (exp. date, if any) _____

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.	First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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, sex, 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, sex, 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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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. 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
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		**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		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A,
Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

VNS CAREGIVERS INC

Acknowledgment of Job Titles/Descriptions and Rates

I understand that I am hired as a per diem employee and that assignments may be on a case by case basis based on my qualifications and availability. The positions listed below are a brief description and the base rate of pay. Rates of pay are subject to change per assignment/client needs. ***** **The brief job descriptions and responsibilities are taken from the actual job description. Refer to the actual job description for complete duties and responsibilities.**
***I have checked the job title/description(s) for which I will agree to work and have signed below.**

☐ **Homemaker/Companion/Rate $16.00-$16.94**
Responsible for non-medical, in-home support services which provide for the comfort and safety, and general supervision of clients as well as home management services and medication reminders. Provides companionship/homemaking to those individuals requiring socialization and/or minimum guidance to assure a safe, protected, clean and orderly environment.

☐ **PCA Intern/Cover/Part-Time/Rate $14.90-$15.00**
Tasks performed shall always relate to personal care needs of the client and medication reminders. Care must include the provision of "hands-on" personal care. Services needed shall maintain to client's health or facilitate treatment of the client's illness or injury during each visit.

☐ **PCA/Home Health Aide/Office Staff/Rate $17.00-$18.50**
Tasks performed shall always relate to personal care needs of the client and medication reminders. Care must include the provision of "hands-on" personal care. Services needed shall maintain to client's health or facilitate treatment of the client's illness or injury during each visit.

☐ **CNA/Home Health Aide/Rate $17.00-$19:00**
Help clients by supporting personal hygiene and daily living needs and perform services consistent with companion and homemaker and provide medication reminders as described above. Maintain client stability by monitoring and reporting any changes in behavior and/or condition.

☐ **Live-In/Rate $180.00 per day (12 hours)**
Perform PCA/CNA duties and responsibilities in support of the patient's care needs and safety.

☐ **Live-In/Rate $260.00 per day (24 hours)**
Perform PCA/CNA duties and responsibilities in support of the patient's care needs and safety.

☐ **ABI/ABH (Acquired Brain Injury) – Companion, Homemaker, PCA/Rate $16.00-$16.94**
The ABI positions are consistent with the chore, companion, homemaker and PCA descriptions as listed above while servicing clients with an ABI.

☐ **ABI/ABH/RA (Recovery Assistant I) Rate $17.00-$18.50**
Promote participant's strengths and abilities to maintain and foster community living skills in the participant's plan of care. Activities include improving socialization; self-advocacy; the development of natural supports; communication and coordination with service providers and others in support of the participant. Can provide ADL's and have a role cueing with support of a med box for medications.

☐ **ABI/ABH/RA (Recovery Assistant II) Rate $ 17.00-$19.00**
Assists the individual with safety monitoring; assistance with activities of daily living (hands-on and cueing) and integration into the community. Services provided in the individual's residence or I n the community. Provide health and safety monitoring.

☐ **ILST (Independent Learning Skills Training)/Rate $25.00-$28.00**
Services delivered independently or in the community. Follow Cognitive/Behavioral Plans. Provide ILST to include assessment and training in: self-care; medication management; task completion; communication and interpersonal skills; socialization; sensory/motor skills; mobility and community transportation skills; problem solving skills; and money management and ability to maintain a household.

☐ **CFC Support and Planning Coach (CFCSPC) $30.00-$35.00**
Support the client in hiring PCA under the mental health waiver program. Must have completed the CFC Support and Planning Coach EVV training and have thorough knowledge of Sandata EVV and Assist client with all aspects of EVV Maintenance, Payroll and Billing through Sandata. Must have completed the Person-Centered Planning Training and has received a Certificate of Achievement from the Department of Social Services. Each individual staff identified as providing Support and Planning Coach Services will not also perform Personal Care Attendant (PCA) services to the same CFC Consumer-Employer. Ensures that documents will be kept on record and accurately maintained.

Name: _____ Date: _____

Signature: _____