Employee Packet

Date of Completion: _____

Enrollment Forms Overview

Welcome! As your FEA, we look forward to working with you. This Employee Packet has the forms and information you need to become an employee. The participant, who is your employer, can help you complete this packet. The employer's signature is needed on some of the forms. You or your employer need to return the packet when complete. As your FEA, it is our job to make sure you payroll is processed accurately on behalf of your employer, the participant. The participant will be notified when your paperwork has been processed. Once notified, you can begin working!

Phone: 877-901-5827
Fax: 866-463-7589
Email: outreach.nc@outreachfiscalagent.com
Website: outreachhealthnorthcarolina.com

FORM	PURPOSE
Enrollment Checklist	This form lists the forms that are required to enroll. Use this checklist as a guide to ensure all forms are completed.
Employee Application	Basic contact information is recorded on this form.
Criminal Record Check Consent Form	Signing this form allows your FEA to conduct a national criminal history check and receive the results.
Participant-Employee Agreement	This form outlines the roles and responsibilities for each party. It also establishes employee wage and work hours. By signing this form, the employee agrees to follow policies and procedures.
Form I-9	This form confirms your identity and your eligibility to work in the United States. You must complete section 1 of this form. The participant completes section 2 by examining your supporting documents from either list A or lists B and C. **Please attach the supporting documents.**
Form W-4	This form is for federal tax purposes and taxes are withheld based on how you complete this form.
Form NC-4 or NC4EZ	This form is used for state tax purposes. Depending on how you complete this form, the FEA will withhold taxes according to your selection.
Employee Relationship Forms	Please fill this form out based on your relationship with the participant. This is used for exemptions in payroll taxes if you are related to the participant.
Pay Selection Options Form	This form is 2 pages and is used for pay selection options (Pay Card or Direct Deposit).

Other Information in the Packet:

- Electronic Time Submittal Instructions & Paper Time Sheet if needed
- Payroll Calendar
- Employee Training Materials – Universal Precautions, Safe Lifting, HIPAA and Confidentiality
- Preventing Medicaid Fraud Handout
- Signs and Symptoms of Abuse, Neglect & Exploitation
- NC CAP EVV Attestation Form

New Employee Packet Checklist

First	Last	First	Last
Print Participant Name		**Print Name of Employee**	

Please use this checklist to ensure all forms are completed and returned. Call us if you have questions or need assistance. Please also return the initialed form along with the completed packet by email or fax:

Email: Outreach.NC@outreachfiscalagent.com
Fax: 866-463-7589

	Participant	Employee
1. Employee Application	_____	_____
2. Form I-9 Employment Eligibility Verification	_____	_____
4. Form W-4	_____	_____
4. Form NC4 or NC4-EZ	_____	_____
5. Employee Information Form/ Relationship Disclosure	_____	_____
6. Direct Deposit Authorization/Pay Selection Options	_____	_____
8. Participant-Employee Agreement	_____	_____
9. Criminal Record Check Consent Form	_____	_____
10. CPR Certification.	_____	_____

Participant/Employer Signature *Date*

Employee Signature *Date*

Acumen Fiscal Agent
Innovation • Opportunity • Freedom

EMPLOYMENT APPLICATION

Client who you are applying to work for:	Employer Name:

PERSONAL INFORMATION:

Last Name	First Name	Middle Initial
Street Address	City	State/Zip
Best Contact Phone #	Email Address	
Date of Birth	SSN #	

A copy of a valid driver's license/ID and a copy of your Social Security Card must be submitted with the application*

EMPLOYMENT ELIGIBILITY:	**RESPONSE:**
Are you currently employed:	
Date available for Employment:	
How many hours a week can you work?	
Are you 18 years of age or older?	
Are you a United States citizen or an alien authorized to work in the United States?	
Have you ever been convicted of a crime, which has not been annulled, expunged or sealed by court? (A yes response does not automatically disqualify your application) If so please list the convictions	

EDUCATION:	**RESPONSE:**
High School Graduate or Equivalent (GED) (Required)	
Certificates or training completed (include expiration dates):	
College Degree:	
Highest Grade completed:	
Degree/Field of Study and completion date:	

LIST PREVIOUS JOBS YOU HAVE HAD (BEGINNING WITH MOST RECENT):

Job Title		**Dates Employed**
Reason for leaving		
Employer	Supervisor	Supervisor #
Address	Starting Salary	Ending Salary
Duties and Responsibilities		

You ____ can _____cannot contact my current/former employer. If not, reason:		
Job Tittle	**Dates Employed**	
Reason for leaving		
Employer	Supervisor	Supervisor #
Address	Starting Salary	Ending Salary
Duties and Responsibilities		
You ____ can _____cannot contact my current/former employer. If not, reason:		

ACKNOWLEDGEMENT:

I, _____(print name), the applicant, certify that the *information provided is true and correct* to the best of my knowledge. I understand that any false statement, omission, or misrepresentation on this application is sufficient cause for refusal to hire, or dismissal if employer has employed me, no matter when discovered by employer. I also acknowledge that ***a background check is required*** and that some convictions prevent employment.

I authorize this potential employer to investigate all statements contained in this application, and I authorize my former employers and references to disclose information regarding my former employment, character, and general reputation, without giving me prior notice of such disclosure.

I understand and agree that nothing contained in this application, or conveyed during any interview, is intended to create an employment contract. I further understand and agree that if I am hired, my employment will be "at will" and without fixed term, and may be terminated at any time, with or without cause and without prior notice, at the option of either myself or this employer. No promises regarding employment have been made to me, and I understand that no such promise or guarantee is binding upon this employer unless made in writing.

_____ _____

Applicant Signature *Date*

EOR Name: ____________________________

EMPLOYMENT PROFILE

Authorization Form to be Fully Completed & Signed

******** Please Print Clearly ********

Human Resource ProFile, Inc.
8506 Beechmont Ave.
Cincinnati, OH 45255-4708
800-969-4300 / 513-388-4300
Fax 513-388-4320

APPLICANT INFORMATION

Name__________________________, ________________________________ ________________________
Last First Middle

Date of Birth ______/______/_________ *Age is not a criterion in any decision, but is used for identification purposes ONLY.*
Month Day Year

Social Security #________________________________

Please list all residences for the past seven (7) years (use an additional sheet of paper, if needed), starting with current address:

Street Address____

City________________________________ County______________________ State________ Zip______________

Dates at this address: ___/___ to (CURRENT) Last Name(s) used if different than current name:______________________
MM YY

City________________________________ County______________________ State________ Zip______________

Dates at this address: ___/___ to ___/___ Last Name(s) used if different than current name:______________________
MM YY MM YY

City________________________________ County______________________ State________ Zip______________

Dates at this address: ___/___ to ___/___ Last Name(s) used if different than current name:______________________
MM YY MM YY

City________________________________ County______________________ State________ Zip______________

Dates at this address: ___/___ to ___/___ Last Name(s) used if different than current name:______________________
MM YY MM YY

City________________________________ County______________________ State________ Zip______________

Dates at this address: ___/___ to ___/___ Last Name(s) used if different than current name:______________________
MM YY MM YY

City________________________________ County______________________ State________ Zip______________

Dates at this address: ___/___ to ___/___ Last Name(s) used if different than current name:______________________
MM YY MM YY

City________________________________ County______________________ State________ Zip______________

Dates at this address: ___/___ to ___/___ Last Name(s) used if different than current name:______________________
MM YY MM YY

City________________________________ County______________________ State________ Zip______________

Dates at this address: ___/___ to ___/___ Last Name(s) used if different than current name:______________________
MM YY MM YY

I have been informed in writing that a consumer report or investigative consumer report may be obtained on me for employment purposes. I hereby authorize the procurement of the report and authorize and direct the release to Human Resource ProFile, Inc., an independent contract agency, information held by any parties regarding my previous employment, my criminal history record and/or record of convictions in federal, state and local files for violations of any federal, state, local statutes or ordinances, my credit history, workers' compensation history, driving record, government agency lists, and scholastic records and hereby release said persons, schools, companies, courts, agencies, and law enforcement authorities from any liability for any damage whatsoever for issuing this information. I further understand this information may be reviewed periodically by Human Resource ProFile, Inc. and reported to my prospective/current employer. I hereby acknowledge that Human Resource ProFile, Inc. cannot vouch for or guarantee the accuracy of information provided by third parties. Accordingly, I release Human Resource ProFile, Inc., its agents and/or my prospective/current employer from any and all liabilities arising out of any errors or omissions regarding my background information and authorize Human Resource ProFile, Inc. to release any and all information to my prospective/current employer.

Applicant Signature____**Date** ________________

TO BE COMPLETED BY EMPLOYER

From : ________________________ Employer Name:____________________ Client Initials:_______

Date Sent ____________________ Time Sent ____________________ Acct # ADFIN-NC

[X] All-County Criminal History [X] National Criminal Database [X] National VSOS

[ ] Special Request____

When requesting a report for employment purposes from HRP, you must also certify to HRP that you have provided the applicant/employee with the disclosure form and obtained the applicant/employee's consent to procure the report. HRP's two page Profile Form complies with these requirements.

Employment Screening and Drug Testing

IMPORTANT DISCLOSURE

FCRA Required
Clear and Conspicuous Notice

Please read before completing and signing the Employment ProFile Form.

I HAVE BEEN INFORMED IN WRITING AND ACKNOWLEDGE THAT A "CONSUMER REPORT" AND/OR AN "INVESTIGATIVE CONSUMER REPORT" MAY BE OBTAINED ON ME FOR EMPLOYMENT PURPOSES. I UNDERSTAND THAT SUCH REPORTS MAY INCLUDE INFORMATION REGARDING MY CREDIT HISTORY, CRIMINAL RECORD, EDUCATION HISTORY, WORK HISTORY, AS WELL AS MY CHARACTER, GENERAL REPUTATION,PERSONAL CHARACTERISTICS, OR MODE OF LIVING. AN "INVESTIGATIVE CONSUMER REPORT" INVOLVES PERSONAL INTERVIEWS OF SOURCES SUCH AS YOUR NEIGHBORS, FRIENDS, OR ASSOCIATES TO OBTAIN INFORMATION AS TO YOUR CHARACTER, GENERAL REPUTATION,PERSONAL CHARACTERISTICS, AND MODE OF LIVING.

I FURTHER UNDERSTAND THAT THIS "CONSUMER REPORT" AND/OR "INVESTIGATIVE CONSUMER REPORT" WILL BE COMPLETED BY HUMAN RESOURCE PROFILE AND PROVIDED TO MY PROSPECTIVE/CURRENT EMPLOYER FOR EMPLOYMENT PURPOSES I ALSO UNDERSTAND THAT I HAVE CERTAIN RIGHTS THAT ALLOW ME TO DISPUTE ANY ERRONEOUS INFORMATION CONTAINED IN MY REPORT.

I FURTHER UNDERSTAND THAT WITH RESPECT TO ANY "INVESTIGATIVE CONSUMER REPORT" THAT MAY BE REQUESTED BY MY PROSPECTIVE/CURRENT EMPLOYER, I HAVE THE RIGHT TO REQUEST FROM MY PROSPECTIVE/CURRENT EMPLOYER DISCLOSURE OF THE NATURE AND SCOPE OF THE "INVESTIGATIVE CONSUMER REPORT" AS WELL AS A WRITTEN SUMMARY OF THE RIGHTS OF CONSUMERS TO OBTAIN AND DISPUTE INFORMATION IN CONSUMER REPORTS.

I ALSO ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS STATEMENT.

Signature_____ **Date**_____

Human Resource ProFile, Inc.
8506 Beechmont Avenue * Cincinnati, OH 45255-4708 * 800/969-4300 * 513/388-4300 * Fax 513/388-4320

STATE LAW NOTICES AND DISCLOSURES – BACKGROUND INVESTIGATION

Pursuant to state law, the following disclosures are provided to state residents.

CALIFORNIA applicants or employees only: By signing below, you acknowledge receipt of this NOTICE – BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check the box if you would like to receive a copy of the investigative consumer report, free of charge, if one is obtained by my prospective employer or its subsidiaries.

☐ YES, I am a California Applicant and I request to receive a free copy of any investigative consumer report ordered on me by checking this box.

☐ YES, I am a California Applicant and I hereby waive my right to obtain a copy of the consumer report by checking this box.

NEW YORK applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by my prospective employer or its subsidiaries by contacting Human Resource ProFile, Inc., 8506 Beechmont Avenue, Cincinnati, OH 45255, Phone: 800-969-4300.

NEW YORK applicants or employees only: By signing below, you acknowledge receipt of a copy of Article 23-A of the New York Correction Law.

WASHINGTON applicants or employees only: You have the right to request from Human Resource ProFile, Inc. a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

MAINE, MASSACHUSETTS, MINNESOTA, NEW JERSEY, and OKLAHOMA applicants or employees only: Please check the box if you would like to receive a copy of your consumer report, free of charge, if one is obtained by my prospective employer or its subsidiaries.

Check box to receive report: ☐

VERMONT applicants or employees only:
Pursuant to 9 V.S.A. §§ 2480e and 2480g, no person may request a credit report on you unless it is obtained pursuant to the order of a Court having jurisdiction or it has secured your written consent to do so and is used for the purpose for which you consented. Credit reporting agencies must adopt reasonable procedures to assure maximum compliance with such requirements. The foregoing shall not affect (1) the ability of a person, who has secured such consent, to include in the same request permission to also obtain credit reports, in connection with the same transaction or credit extension, for the purpose of reviewing, increasing the credit line on, taking collection on, or for other legitimate purpose regarding, your account; or (2) the use of credit information for the purpose of prescreening as defined and permitted by the Federal Trade Commission.

Signature: _____

Date: _____

Print Name: _____

Participant/Employer-Employee Agreement

This agreement is between _____(Participant) and the _____ (Employee). The purpose of this agreement is to outline roles and responsibilities of each party, describe employee job duties and identify the hourly wage for employee. Please review each item.

1. The employee's wage per hour is $_____. Wages are subject to state and federal withholding taxes. A new participant-employer agreement will be signed if the wage changes.
2. The employee will work _____hours a week. Hours worked are subject to change at direction of the participant but must never exceed authorized hours on the Plan of Care unless approved by the Care Advisor.
3. The employee is an employee of the participant (named above) and not my participant's FEA.
4. This is an at-will employment agreement. The employer or the employee can cancel this agreement at any time, for any reason. If the employee can no longer work, it is essential to give advanced notice (two weeks) so the participant can recruit, hire and train a replacement.
5. Roles and Responsibilities of each party:
    a. Participant/representative responsibilities include, but are not limited to:
        i. Hiring, scheduling, orienting, training, supervising and terminating the employee. Treating the employee with respect.
        ii. Coaching the employee and consistently giving the employee feedback up to and including termination, if applicable.
        iii. Training the employee. The following training materials have been provided:
            1. Signs and Symptoms of Abuse & Neglect and Exploitation
            2. Preventing Medicaid Fraud
            3. Employee Training Booklet: Universal Precautions, Safe Lifting and HIPAA & Confidentiality
        iv. Home and Community-based Planning Training (NC Medicaid will provide you this document) Reviewing the Plan of Care with the employee.
        v. Submitting employee time worked accurately and timely online or by paper time sheets.
        vi. Monitoring that the employee only works approved hours according to Plan of Care, does not work over time and does not work when in the hospital, acute rehabilitation or skilled nursing facility.
        vii. Notifying the FEA immediately if an employee is terminated.
        viii. Reviewing the Employment Resource Guide with the employee (The Guide gives information about Federal and state employment law and regulations and the FEA's policies and procedures); the Handbook is also available on the FEA website.
        ix. Other responsibilities as outlined in the Participant Agreement.
    b. The employee responsibilities include, but are not limited to:
        i. Providing safe and excellent care to the participant
        ii. Submitting time worked, either online or by faxing paper time sheet
        iii. Working hours and performing tasks approved on the participants Plan of Care. The employee is considered a mandated reporter and must immediately report any concerns of abuse, neglect or exploitation to the appropriate authority (the police or 911), the Department of Social Services county in which the participant lives. If additional help is needed call the North Carolina Department of Health and Human Services CARELINE 1-800-662-7030, and the participant's Care Advisor or the FEA

iv. Reporting concerns of Medicaid Fraud to the North Carolina Division of Medical Assistance **1-877-362-8471** and my FEA or my Care Advisor
v. Immediately report all incidents, accidents and work place injuries involving the employee or the participant. If an employee is injured on the job, it should also be reported to the participant (employer). Work place injuries must be reported to the FEA Employee Injury Line **877-901-5827**
vi. Notifying my FEA immediately if there is a change in name, address, telephone and any criminal convictions occurring after date of hire
vii. Reporting any customer service concerns or complaints to your FEA
viii. Maintaining active certification in CPR when employed to provide services to individuals under the age of 21
ix. Maintaining competency validations during each annual reassessment period
x. Maintaining active certification in CPR when employed to provide services to individuals under the age of 21
xi. Maintaining competency validations during each annual reassessment period

c. FEA responsibilities include, but are not limited to:
    i. Sending the participant required employee paperwork, if needed (all forms are on the FEA website)
    ii. Helping in the completion of required paperwork, if needed
    iii. Processing employee paperwork and determining employee eligibility and conducting background check
    iv. Providing workers compensation to participants who have two or more employees according to state law
    v. Paying the employee and processing employee taxes and benefits
    vi. The employee will only be paid for approved hours on the Plan of Care. The employer, not your FEA, is responsible for paying the employee for time worked in situations when:
        1. The participant becomes ineligible for Medicaid.
        2. The employee works more hours than approved or for tasks not approved on the participant's Plan of Care.
        3. The employee works before approved to do so by the FEA
        4. The participant is in the hospital, acute rehabilitation unit or skilled nursing facility.
        5. Hours worked after the participant's budget has run out or expired.

6. The employer approves the FEA to automatically withhold money from his/her employee in situations when:
    a. The employee is paid at a higher rate than what is budgeted, or paid for hours not worked
    b. The employee is inaccurately paid
    c. The employee receives duplicate payment and cashes both payments
7. If an employee recoupment of funds is necessary, the FEA will contact the employer and employee to outline a repayment plan.
8. The participant and employee both agree to follow the payroll schedule as provided at the time of this agreement and thereafter as the schedule changes.
9. Time worked must be submitted every Monday by midnight.
10. The participant and employee understand that a delay in Medicaid or service eligibility may sometimes occur. While the participant is authorized for Medicaid, eligibility may not reflect this in the NC Medicaid

system referred to as NCTracks. If this happens, as the FEA, we will pay the employee for two pay periods. If the delay continues, payment may be stopped. Both the participant and employee will be notified before this occurs as well notifying the Care Advisor.

The participant and employee signatures indicate acceptance of the terms and conditions outlined in this agreement.

Participant or Legal Guardian Name: _____

_____ _____

Participant or Legal Guardian Signature *Date*

Employee Name: _____

_____ _____

Employee Signature *Date*

Please pay close attention to the following Federal form.

This form is detailed and needs your *close attention* to complete correctly.

Incomplete forms may result in penalties.

Call for assistance if needed. We are here to help!

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

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. A noncitizen (other than **Item Numbers 2.** and **3.** above) 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

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

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, 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 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.
		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		
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				

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 07/31/2026

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 07/31/2026

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.

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

2024

Step 1: Enter Personal Information

Physical Address Required (No P.O. Box)

(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 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.)

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 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**

If applicable -->

(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 (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (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

Required field even if "0".

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 for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

Optional. Please refer to the instructions.

(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)** $

If filing exempt, leave Steps 2, 3 & 4 blank. Write EXEMPT here --->

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 Name Here

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

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

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

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

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

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

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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

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

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

NCDOR
Web
11-21

NC-4EZ
Employee's Withholding Allowance Certificate

Filing Status (Mark one box only) ☐ Single or Married Filing Separately ☐ Head of Household ☐ Married Filing Jointly or Surviving Spouse

Social Security Number ☐☐☐-☐☐-☐☐☐☐

First Name | M.I. | Last Name

Address | County *(Enter first five letters)*

City | State | Zip Code | Country *(If not U.S.)*

Instructions. Use Form NC-4EZ if you:

- Plan to claim the N.C. Standard Deduction
- Plan to claim the N.C. Child Deduction Amount (but no other N.C. deductions)
- Do not plan to claim N.C. tax credits
- Qualify to claim exempt status (See Lines 3 or 4 below)

Important. If you plan to claim N.C. itemized deductions or plan to claim other N.C. deductions (other than the N.C. Child Deduction Amount), you must complete Form NC-4. If you are a nonresident alien, you must complete Form NC-4 NRA. In general, a nonresident alien is an alien (not a U.S. citizen) who has not passed the green card test or the substantial presence test. *(See Publication 519, U.S. Tax Guide for Aliens, for more information on the green card test and the substantial presence test.)*

If you plan to claim the N.C. Child Deduction Amount, use the table below for your filing status, amount of income, and number of children under age 17 to determine the number of allowances to enter on Line 1. For married taxpayers, only one spouse may claim the allowance for the N.C. Child Deduction Amount for each child.

Single & Married Filing Separately										
Income	# of Children under age 17									
	1	2	3	4	5	6	7	8	9	10
	# of Allowances									
0 - 20,000	1	2	3	4	6	7	8	9	10	12
20,001 - 30,000	1	2	3	4	5	6	7	8	9	10
30,001 - 40,000	0	1	2	3	4	4	5	6	7	8
40,001 - 50,000	0	1	1	2	3	3	4	4	5	6
50,001 - 60,000	0	0	1	1	2	2	2	3	3	4
60,001 - 70,000	0	0	0	0	1	1	1	1	1	2
70,001 and over	0	0	0	0	0	0	0	0	0	0

Married Filing Jointly & Surviving Spouse										
Income	# of Children under age 17									
	1	2	3	4	5	6	7	8	9	10
	# of Allowances									
0 - 40,000	1	2	3	4	6	7	8	9	10	12
40,001 - 60,000	1	2	3	4	5	6	7	8	9	10
60,001 - 80,000	0	1	2	3	4	4	5	6	7	8
80,001 - 100,000	0	1	1	2	3	3	4	4	5	6
100,001 - 120,000	0	0	1	1	2	2	2	3	3	4
120,001 - 140,000	0	0	0	0	1	1	1	1	1	2
140,001 and over	0	0	0	0	0	0	0	0	0	0

Head of Household										
Income	# of Children under age 17									
	1	2	3	4	5	6	7	8	9	10
	# of Allowances									
0 - 30,000	1	2	3	4	6	7	8	9	10	12
30,001 - 45,000	1	2	3	4	5	6	7	8	9	10
45,001 - 60,000	0	1	2	3	4	4	5	6	7	8
60,001 - 75,000	0	1	1	2	3	3	4	4	5	6
75,001 - 90,000	0	0	1	1	2	2	2	3	3	4
90,001 - 105,000	0	0	0	0	1	1	1	1	1	2
105,000 and over	0	0	0	0	0	0	0	0	0	0

1. **Total number of allowances you are claiming** *(Enter zero (0), or the number of allowances from the table above)* _____

2. **Additional amount, if any, you want withheld from each pay period** *(Enter whole dollars)* _____.00

3. **I certify that I am exempt from North Carolina withholding because I meet both of the following conditions:**
   - Last year I was entitled to a refund of all State income tax withheld because I had no tax liability; **and**
   - This year, I expect a refund of all State income tax withheld because I expect to have no tax liability.

   Check Here ☐

4. **I certify that I am exempt from North Carolina withholding because I meet the requirements set forth in the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act and Veterans Benefits and Transition Act.** ***(See Form D-401, North Carolina Individual Income Tax Instructions, for more information.)***

   Check Here ☐

   If an exemption on Line 3 or Line 4 applies to you, enter the year the exemption became effective _____ *YYYY*

5. **I certify that I no longer meet the requirements for an exemption on Line 3** ☐ **or Line 4** ☐ *(Check applicable box)*

   Therefore, I revoke my exemption and request that my employer withhold North Carolina income tax based on the number of allowances entered on Line 1 and any additional amount entered on Line 2.

   Check Here ☐

CAUTION: If you furnish an employer with an Employee's Withholding Allowance Certificate that contains information which has no reasonable basis and results in a lesser amount of tax being withheld than would have been withheld had you furnished reasonable information, you are subject to a penalty of 50% of the amount not properly withheld.

Employee's Signature _____ **Date** _____

I certify, under penalties provided by law, that I am entitled to the number of withholding allowances claimed on Line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on Line 3 or 4, whichever applies.

Employee Information Form
Relationship Disclosure

Employee Name: _____ SSN: _____

Physical Address: _____ City/State/Zip: _____

Mailing Address (if different): _____ City/State/Zip: _____

County of Physical Address: _____

Phone Number: _____ Email (optional): _____

Name of Participant: _____

Name of Employer (if applicable): _____

Instructions: There are some tax exemptions for certain domestic employer and employee relationships. Please select any of the below boxes if a relationship exists between you as the employee and the employer:

- ☐ ***None***, no relation to employer
- ☐ ****Spouse*** of the employer,
- ☐ ****Child*** of the employer and under the age of 21
- ☐ ****Parent*** of the employer - if this option is marked, read below and check all that apply:
  - ☐ ***You are employed by your son or daughter***
  - ☐ ***Your son or daughter has a child or stepchild living in the home***
  - ☐ ***Your son or daughter is a widower, divorced, or is living with a spouse who, because of a mental or physical condition, cannot care for the child or stepchild for at least 4 continuous weeks in a calendar quarter***
  - ☐ ***Your son or daughter's child or stepchild is under the age of 18 and requires the personal care of an adult for at least 4 continuous weeks in a calendar quarter due to a mental or physical condition***

*Internal Use Only
• If Parent (employee) selected all 4 parent conditions, parent/employee is **FUTA and SUTA Exempt** • If Parent (employee) did **NOT** select all 4 parent conditions, parent/employee is **FICA, FUTA, SUTA Exempt**
• If Spouse or Child are selected, employee is **FICA, FUTA, SUTA Exempt**

The fine print - under IRS guidelines, Publication 15 (Circular E) Section 3, employees are not subject to Social Security, Medicare and federal unemployment tax (FUTA) if these relationships exist. The exemptions are as follows:

A. Child employed by parents – Payments for work other than in a trade or business, such as domestic work in the parent's private home, are not subject to Social Security, Medicare, and FUTA tax until the child reaches age 21. (*IRS Pub.15, Section 3, Paragraph 1*)

B. One spouse employed by another – Payments for services of one spouse employed by another in other than a trade or business, such as domestic service in a private home, are not subject to Social Security, Medicare, and FUTA tax. (*IRS Pub.15, Section 3, Paragraph 2)*

C. Parent employed by child – Payments for the services of a parent employed by his or her child in other than a trade or business, such as domestic services, are not subject to Social Security, Medicare and FUTA tax as long as the above conditions apply. (*IRS Pub.15, Section 3, Paragraph 4)*

The State of North Carolina follows the federal guidelines in applying liability for state unemployment tax (SUTA). If the Caregiver falls into the category of Spouse or Child as outlined above, Social Security and Medicare tax will not be withheld from their checks. If the Caregiver falls into the category of Parent and meets all 4 parent conditions, Social Security and Medicare tax **will** be withheld from their checks. If the employee is exempt from FUTA, SUTA, Social Security and Medicare, the employer will not be charged for their share of Social Security and Medicare or FUTA and SUTA withholdings.

Employee Signature: _____ Date: _____

Phone: (877) 901-5827 Fax: (866) 463-7589 outreach.NC@outreachfiscalagent.com

Acumen Fiscal Agent
Innovation • Opportunity • Freedom

Pay Selection Options

Below are the options employees have for receiving their paychecks through Acumen. Please read the information about each option and select the one that is right for you. Paystubs will be sent through DCI Message Center. Your login information will be provided on your Good to Go. **You will need to provide additional information based on your selection; please read the instructions below and return all the necessary forms.**

Direct Deposit

With this option, your paycheck will be automatically deposited into your bank account on payday. There is no charge from Acumen to receive your pay via direct deposit. You won't have to wait for the mail or make a trip to the bank. On payday, paystubs will be sent via DCI messaging. You can have your paycheck deposited into one or two accounts, and you may change your account information at any time. **Please note:** You have the option to deposit a flat dollar amount **or** a percentage amount of your check to the primary account. If you choose to have a flat dollar amount deposited into your primary account, you will need to provide a secondary account in which the remainder of the funds will be deposited to. If you choose to have a percentage amount of your check deposited into two accounts, you must indicate the percentage to be deposited to each. The percentage total must be 100%. If no amounts are indicated, 100% will be deposited into the primary account. To enroll, fill out the information on the Authorization for Direct Deposit section of the form and return it, along with the additional requested items, to Acumen. You will receive paper checks by mail until your bank information is verified – usually within two pay periods.

Pay Card

Pay cards – also called pre-paid debit cards – work just like a regular debit card but are used only for payroll deposits. Acumen does not charge for this option, although the card provider may charge fees for certain transactions. Pay cards are up to 80% less expensive to use than check cashing services. Paystubs will be delivered via DCI messaging on payday. To enroll, complete the Authorization for Pay Card section of the form and return it to Acumen. Money Network will send you an information kit. You will need to activate the card with Money Network and then contact Acumen with your account information. You will receive paper checks by mail until this process is complete. For a complete fee schedule, see: https://docs.moneynetwork.com/moneynetwork/prepaid-fees.html

Please return the completed form to Acumen. You may send by email, fax, or mail listed below:

Email: Outreach.NC@Outreachfiscalagents.com
Fax: (866)-463-7589
Mail: 5416 E Baseline Rd, Suite 200, Mesa, AZ 85206

Note: if you do not select one of the options, Acumen will send your paycheck via regular mail, according to the established pay schedule you have received. We make every effort to get your check to you by payday; however, it is impossible to guarantee the date that paper checks will arrive. Acumen is not responsible for any delays or misdirected mail after checks have been submitted to the U.S. Postal Service. If your paper check does not arrive within 5 business days of payday, you can call Acumen to issue a stop payment and have a new check issued. A processing fee of $35.00 will be deducted from the new check for each stop payment request. This fee may be waived by signing up for direct deposit or pay card.

I choose to receive my pay by (please check one box below):

Check □ Direct Deposit □ Pay Card □

DIRECT DEPOSIT INFORMATION

Please attach a voided check or **bank letter** for checking or savings account(s). For savings accounts, please send a printout from your bank that provides the routing number and account information. Submit any changes to your account(s) immediately!

Primary Account 1 Account Type: ☐ **Checking** (attach a voided check) ☐ **Savings** (attach routing & account information printout)	**Secondary Account 2 (Mandatory for Flat dollar option)** Account Type: ☐ **Checking** (attach a voided check) ☐ **Savings** (attach routing & account information printout)
☐ **Flat Dollar Amount** ☐ **Percentage**	☐ **Remainder account. (**Used if percentage is less than 100% or net pay exceeds the flat dollar amount listed for Primary Account 1)
Financial Institution Name	Financial Institution Name
Financial Institution Address	Financial Institution Address
Routing Number	Routing Number
Account Number	Account Number
Flat dollar **amount or %** of check to be deposited:	All remaining funds exceeding Primary Account 1 allocations will deposit into this account.

Are you the account holder for the account(s) listed above? ☐ Yes ☐ No

If "no," what is the name of the account holder? _____

If "no," employee agrees to have their funds deposited into this account._____

Employee Signature

AUTHORIZATION FOR DIRECT DEPOSIT or PAY CARD or PAPER CHECK

I hereby authorize Acumen Fiscal Agent, LLC (herein after "Company") to deposit any amount owed to me for wages and/or reimbursements by initiation of credit entries to my account at the financial institution (hereinafter "Bank") handling my choice indicated above. Further, I authorize Bank to accept and credit any credit entries indicated by Company to my account. In the event that Company deposits funds erroneously into my account, I authorize Company to debit my account for an amount not to exceed the original amount of the erroneous credit. This authorization is to remain in full force and effect until Company receives written notice from me of its termination in such time and in such a manner as to afford a reasonable opportunity to act on it. If my method of payment is pay card, as the pay card holder, it is my responsibility to close this account should I no longer choose to have payments deposited in this manner. If I selected Paper Check, I understand that Acumen will make every effort to ensure my check will arrive by payday; however, it is impossible to guarantee the date that my paper check will arrive. Acumen is not responsible for any delays or misdirected mail after checks have been submitted to the U.S. Postal Service. If my paper check does not arrive within 5 business days of payday, I can call Acumen to issue a stop payment and have a new check issued. I understand that if I request a stop payment, a processing for of $35.00 will be deducted from my new check. If I require that this fee be waived, I must sign up for either direct deposit or a Pay Card. I understand that the Money Network pay card will have fees for transactions, and that I will be responsible for these fees if I choose this option. I understand that I may elect to have direct deposit to an existing pay card that is already in my name, as long as I provide supporting documentation to verify the routing & account number and name on the account. I understand that Acumen is not liable for any pay card fraudulent activity related to third party transactions. I understand that upon my request, Acumen may attempt a payment reversal. However, if the reversal is not successful, I understand that Acumen is not responsible and I will need to work with my institution to rectify said payment.

_____	_____	_____
Print Name	Social Security Number	Date of Birth
_____	_____	_____
Email Address	Signature	Date

Return completed form by email Outreach.NC@Outreachfiscalagent.com , fax (866) 463-7589 or mail to 5416 E. Baseline Rd., Ste. 200, Mesa, AZ 85206

Attestation to the Employee Live-in Exemption

Under the U.S. Department of Labor Fair Labor Standards Act (FLSA) – Home Care Rule revised regulations, I confirm that my employee listed below qualifies as a live-in domestic service worker and is exempt from the Fair Labor Standards Act overtime requirements.

I attest to the following:

- ***My worker resides on my premises either "permanently" or for "extended periods of time":***
  - ***"Permanently"*** *– My worker resides on my premises permanently by living, working and sleeping on my premises seven days per week and therefore has NO home of his or her own; OR*
  - ***"Extended Periods of Time"*** *– My worker resides on my premises for an extended period of time by living, working and sleeping on my premises for five days a week (120 hours or more) OR My worker spends less than 120 hours per week working and sleeping on my premises, but spends five consecutive days or nights residing on my premises.*
- ***My worker is/will be paid at least minimum wage for all hours worked.***
- ***There is a written agreement signed by my worker and myself to determine the number of hours that my worker will work.***
  - *Sleep time, meal time and other periods of time of complete freedom from work duties are excluded from work hours.*
  - *If any of the designated freedom of time periods are interrupted, I must pay for that time worked.*
  - *My worker may either leave the premises or stay on the premises during the designated freedom time periods.*
  - *If there is ANY deviation to the written agreement, a new agreement must be made.*

By signing below, I acknowledge that I am the employer for this stated employee and that by declaring this exemption, I have complied with the requirements for this exemption and accept any and all legal responsibility including but not limited to any cost associated with litigation or fines that may result by falsely claiming this exemption. I understand that this attestation form does not constitute the written agreement between me and my worker.

Participant/Client Name:_____(Please print)

State: _____

Employer Name:_____(Please print)

Employer Signature:_____Date:_____

Employee/Worker Name:_____(Please print)

Employee/Worker Signature:_____Date: _____

Email: Outreach.NC@Outreachfiscalagent.com

North Carolina CAP/C and CAP/DA
Electronic Visit Verification (EVV) Live-In Caregiver Attestation Form

Per North Carolina Medicaid Policy issued March 23, 2021 titled *Electronic Visit Verification for CAP/C and CAP/DA Waiver Beneficiaries*, waiver recipients who can demonstrate that their employee is a paid live-in caregiver are exempt from having to submit their shifts for payment according to EVV mandates.

This form and supporting documentation must be provided to the Fiscal Agent annually to prove that your employee (live-in caregiver) resides with the waiver recipient. Service dates either before or after the expiration of this form are subject to EVV compliance, per state rule. This form will not be made retroactive, nor will annual renewals of the live-in status be processed retroactively due to the real-time nature of EVV reporting. Please allow a minimum of 5 business days for processing.

If you have an employee who resides with the waiver participant (i.e. a paid live-in caregiver), you must provide the following items annually to be exempt:

1) A signed attestation form;
2) A drivers' license OR another valid photo identification;
3) One additional piece of supporting documentation showing the paid live-in caregiver shares the same address as the waiver recipient. This can be a:
    a. Current Utility Bill
    b. Current Credit Card Statement
    c. Residential Lease Agreement
    d. School enrollment forms (date must be within 3 months of submittal)
    **Other documents require the approval of NC Medicaid.*

Waiver Recipient: _____

Employer Name: _____

Employee/Live-in Caregiver: _____

Shared Address: _____

By signing this document I attest that, to the best of my knowledge, this information is true and correct; and that the above named employee is a paid live-in caregiver for the waiver recipient. I understand that providing false or inaccurate information will be reported and may be considered Medicaid Fraud and subject to consequences, including recoupment of paid claims.

Employer Signature: _____Date: _____

Return this form and supporting documentation to: outreach.nc@outreachfiscalagent.com or fax to 866-463-7589.

NC CAP Payment Schedule
Effective July 1, 2023

To ensure that your employees and/or service providers are always paid on time, please ensure your employee's time is entered and approved online by the due date, even if it falls on a weekend or holiday. These dates are strictly enforced. Any time that is approved after the due date or payment requests received after that date will be processed for the following payment period.

Be sure to have all hours entered and approved by the "Submissions Due NO Later Than" date. To access the DCI Employer and Employee Portal, go to:

http://outreach.dcisoftware.com

If you would like to attend a webinar on how to use either the Mobile App or online Web Time Entry portal, visit www.acumenfiscalagent.com and click on the Events tab. If you have any questions or concerns, contact our Customer Call Center at 877-901-5827.

"MONTH" refers to the month that services were provided.

"Payment Period End Date" is the last day of services in the pay period.

MONTH	Payroll Start Date	Payment Period End Date	Submissions Due NO Later Than	Direct Deposit/Check Date
JULY	7/09/23	7/22/23	7/24/23	8/04/23
	7/23/23	8/05/23	8/07/23	8/18/23
AUGUST	8/06/23	8/19/23	8/21/23	9/01/23
	8/20/23	9/02/23	9/04/23	9/15/23
SEPTEMBER	9/03/23	9/16/23	9/18/23	9/29/23
	9/17/23	9/30/23	10/02/23	10/13/23
	10/01/23	10/14/23	10/16/23	10/27/23
OCTOBER	10/15/23	10/28/23	10/30/23	11/09/23
	10/29/23	11/11/23	11/13/23	11/22/23
NOVEMBER	11/12/23	11/25/23	11/27/23	12/08/23
	11/26/23	12/09/23	12/11/23	12/21/23
DECEMBER	12/10/23	12/23/23	12/25/23	1/05/24
	12/24/23	1/06/24	1/08/24	1/19/24
JANUARY	1/07/24	1/20/24	1/22/24	2/02/24
	1/21/24	2/03/24	2/05/24	2/16/24
FEBRUARY	2/04/24	2/17/24	2/19/24	3/01/24
	2/18/24	3/02/24	3/04/24	3/15/24
MARCH	3/10/24	3/16/24	3/18/24	3/29/24
	3/17/24	3/30/24	4/01/24	4/12/24
	3/31/24	4/13/24	4/15/24	4/26/24
APRIL	4/14/24	4/27/24	4/29/24	5/10/24
	4/28/24	5/11/24	5/13/24	5/24/24
MAY	5/12/24	5/25/24	5/27/24	6/7/24
	5/26/24	6/08/24	6/10/24	6/21/24
JUNE	6/09/24	6/22/24	6/24/24	7/05/24
	6/23/24	7/06/24	7/08/24	7/19/24
	7/7/24	7/20/24	7/22/24	8/02/24

"Direct Deposit/ Check Date" shows the date that payment will be issued. For those payees that have selected direct deposit or pay card, this is also the date that funds will be available in their accounts.

"Submissions Due NO Later Than" is the last date that your employee's time can be approved and your vendor payment requests can be submitted, for the pay period in order to be paid as scheduled.

Please share this schedule with your employees, and keep a copy in a safe place for easy reference.

Acumen Fiscal Agent
5416 E. Baseline Rd., Suite 200
Mesa, AZ 85206

Worker's Compensation
Claim Reporting Guidelines for Employees

If there has been a workplace injury or accident, please take the following action:

- If the injury or accident is of a serious nature, seek medical attention immediately.
- Employees must report the injury immediately to their employer.
- Employers must report the injury as soon as possible even if it is a weekend or holiday to the Acumen Workers' Compensation Department.
- To report to Acumen, call 866-472-2297. If you get voicemail when you call, leave a message with your name, call back number, state you are located in, a brief description of the incident and if the injury is of a serious nature (including hospitalization (not ER room & home release), immediate surgery status, critical care or death) .
- Messages of injuries of a serious nature will be returned even on a weekend or holiday. All other messages will be returned the following business day.

Timely reporting of any injury that goes beyond First Aid treatment to Acumen's Workers' Compensation Department is important. When reporting, be prepared with the following information:

- Time & place the incident occurred as well as how it occurred.
- Explain in as much detail as possible what happened to cause the injury.
- Take pictures of the area where the incident occurred, if you are able to do so, and any other photos you are able to obtain that may be helpful to the claim.

Contact Acumen's Workers' Compensation Administrator. Direct line is 866-472-2297.

What is Medicaid Fraud?

Medicaid fraud involves knowingly misrepresenting the truth about services provided.

Fraud includes:

* Abuse of Medicaid dollars resulting in increased costs.
* Waste which is overusing resources and receiving inaccurate payments for services.

The following are typical schemes used to defraud the Medicaid program:

Billing for Services Not Provided

A caregiver records time worked for services not performed, such as recording time worked preparing and cooking a meal for a participant when the caregiver did not.

Doubling Billing

A participant approves time worked for two caregivers at the same time or approves time worked for a caregiver when the participant was in the hospital.

Billing for Phantom Visits

A participant falsely bills the Medicaid program for caregiver visits that never take place.

Billing for More Hours Than Worked

Inflating the amount of time a caregiver spends with the participant, for example submitting a time sheet that records the caregiver having worked five hours in a day when the caregiver actually worked three.

Unapproved Tasks

Asking a caregiver to perform tasks, like walking a dog, that is not an approved Medicaid task and submitting the time spent on a time sheet.

Non-Eligible Employee

Submitting a time sheet using the name of an employee who is approved to work but a different person actually did the work and receives payment.

Committing Fraud is a Crime. Consequences: Those committing Medicaid fraud can be charged with a felony or misdemeanor and If convicted, they will be required to pay back all money received falsely, and possibly serve time in prison. If you recognize that you have made a mistake on a time sheet, call right away so it can be corrected: **877.901.5827**

If you are concerned that fraud is occurring, call the NC Division of Medical Assistance at **1.800.662.7030** and inform your FEA at **877.901.5827**

SIGNS OF ABUSE, NEGLECT, AND EXPLOITATION

The law protects the health and safety of "vulnerable adults" and children from abuse, neglect, and exploitation. It is important for participants and employees to know signs and symptoms of abuse, neglect and exploitation for health and safety reasons. A vulnerable adult is someone over the age of 65 with a long-term disability. If you have concerns that a "vulnerable adult" or child is being harmed, please report it right away.

Acumen Fiscal Agent

www.outreachhealthnorthcarolina.com
outreach.NC@outreachfiscalagent.com
1-877-901-5827

What is Abuse, Neglect, & Exploitation?

- **ABUSE** is the willful infliction of injury, unreasonable confinement, intimidation, or punishment which results in physical harm, pain or mental anguish. It also includes the deprivation of food, water, shelter, etc. (Includes emotional, physical and sexual abuse).
- **NEGLECT** is the refusal or failure to fulfill any part of a person's obligations to another person, such as the provision of food, clothing, medicine, comfort, or personal safety.
- **FINANCIAL OR MATERIAL ABUSE** or exploitation is the illegal or improper use of a person's funds, property, or assets.
- **SELF-NEGLECT** is an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including providing for one's own food, clothing, shelter, and medical care. Choice of lifestyle or living arrangement is not, in itself, evidence of self-neglect.

WHAT IS ABANDONMENT?

"Abandonment" is when a person or agency with a duty to care for a vulnerable adult or child acts (or fails to act) in a way that leaves the vulnerable adult unable to get needed food, clothing, shelter, or health care.

INDICATORS OF ABUSE, NEGLECT, OR EXPLOITATION

The following descriptions are not necessarily proof of abuse, neglect, or exploitation. But maybe clues that a problem exists, and that a report needs to be made to law enforcement or Adult Protective Services or Child Protective Services.

To report concerns of Abuse, Neglect and Exploitation, contact the Department of Social Services in the county in which you live. If the vulnerable adult is in immediate danger, please call 911

BEHAVIORAL SIGNS

- Fear
- Anxiety
- Agitation
- Acting out
- Anger
- Isolation/withdrawal
- Depression
- Contradictory statements
- Implausible stories
- Hesitation to talk openly
- Confusion or disorientation

PHYSICAL SIGNS

- Forced isolation
- Skin discoloration
- Sunken eyes or cheeks
- Pain from touching
- Soiled clothing or bed
- Inappropriate administration of medication
- Injury that has not been cared for properly
- Injury that is inconsistent with explanation for its cause
- Cuts, puncture wounds, burns, bruises, welts
- Frequent use of hospital or health care/doctor shopping
- Lack of necessities such as food, water, or utilities
- Dehydration or malnutrition without illness-related cause
- Lack of personal effects, pleasant living environment, personal items

FINANCIAL ABUSE

- Unexplained sudden transfer of assets,
- Providing unnecessary services,
- A complaint of financial exploitation,
- Unexplained missing funds or valuables
- Providing substandard care
- Unpaid bills despite having enough money
- Sudden changes in bank account or banking practice
- Adding additional names on a bank signature card
- Unapproved withdrawal of funds using an ATM card
- Sudden changes in a will or other financial documents
- Forged signature for financial transactions or for the titles of property
- Sudden appearance of previously uninvolved relatives claiming their rights to a person's affairs and possessions
- Unexplained withdrawal of a lot of money by person accompanying the victim

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

You have the right to:

Your Rights

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	· You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. · We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	· You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. · We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	· You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. · We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	· You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. · If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	· You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. · We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	· You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	· If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. · We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	· You can complain if you feel we have violated your rights by contacting us using the information on page 1. · You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** · We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	· Share information with your family, close friends, or others involved in your care · Share information in a disaster relief situation · Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	· Marketing purposes · Sale of your information · Most sharing of psychotherapy notes
In the case of fundraising:	· We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	· We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	· We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	· We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	· We can share health information about you for certain situations such as: · Preventing disease · Helping with product recalls · Reporting adverse reactions to medications · Reporting suspected abuse, neglect, or domestic violence · Preventing or reducing a serious threat to anyone's health or safety
Do research	· We can use or share your information for health research.
Comply with the law	· We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	· We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	· We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	· We can use or share health information about you: · For workers' compensation claims · For law enforcement purposes or with a law enforcement official · With health oversight agencies for activities authorized by law · For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	· We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Original Effective Date: 11/06/03 Rev. 09/21/13; Rev. 09/01/2017

This Notice of Privacy Practices applies to the following organizations.

EMPLOYEE SAFETY TRAINING

03/15/2022

Back Safety

As a home care worker, you are exposed to more ergonomic (body movement) hazards than other jobs. These hazards may include bending, twisting, lifting, pushing and pulling and other movements that are repetitive. If these motions are not done correctly, they can lead to injury. It is important to learn proper technique to prevent back and other problems.

You can protect your back by following some simple procedures and by using good decision making. Always remember to:

- Maintain good body posture
- Use safe body mechanics
- ACT safely during transfers and lifts
- Keep in good shape.

Use good posture:

Standing up straight, with shoulders back and your pelvis tucked in, aligns your vertebrae and surrounding muscles. Keep your head up, shoulders back, chest out, stomach in and buttocks tucked. You do not want to hold your body tensely but neutrally.

Safe Body Mechanics:

- Bend at your hips and knees not your waist. Bending at the waist strains the back.
- Use the force of your leg muscles to do the lifting.
- Tilt your pelvis in and contract your stomach muscles when lifting.
- Carry things close to your body. When you carry items away from your body it increases the weight to your back.
- Try to avoid twisting your body when carrying. Instead move your whole body in the direction you need to go.
- Do not lift a load that is too heavy for you by yourself. Get someone to help you.
- Use equipment to move items when possible. For example, use a dolly to take the trash can out if it is heavy.
- Keep your work surface higher than waist level to avoid straining your back.

Protective Devices for Lifting:

Using devices to lift or transfer participants will reduce back stress and prevent worker injury. Limiting manual lifting and transferring, the amount of times you move the participant and confining the transfer to a specific space, like the bathroom where there are grab bars, all reduce worker injury.

Protective devices include:

- Hoists

- Transfer belts (can makes once with a sheet. You have something to hold onto when transferring)
- Shower chairs
- Grab bars
- Walking belts with handles
- Repositioning devices

ACT Safely (Assess, Create, Transfer)

Assess the situation:

- Identify hazards before you begin. For example, a crowded area.
- Can the participant help with the transfer at all? What is his health condition? The participant's assistance can help overload you.
- Talk to the participant when lifting or transferring. The participant can anticipate what is going to occur and will be less anxious and rigid.

Create a safe workplace:

- Make sure you have plenty of room to lift or transfer. Get rid of clutter. Remove lose rugs.
- Have any equipment you need within reach.
- Secure the bed and chair you are moving the participant too.

Transferring the participant:

- Outline the steps of transferring with the participant
- Move the participant to the head of the bed so you can be aligned.
- Put a transfer belt on the participant.
- Make sure the participant has good shoes or non-slip slippers on.
- Move the chair close to the person.
- If transferring to a wheelchair, move the armrest nearest the participant, remove both footrests and lock the wheels.
- First move the participant to the edge of the bed, chair, or couch.
- Move one body part at a time starting with the head, then shoulders the buttocks and the legs and feet last.
- Stay low. Bend your knees and hips, keep your head up and tuck in your pelvis.
- On the count of three or another signal, move to a standing position by pulling on the transfer belt and straightening your knees.
- If the participant really struggles, have him rock back and forth.
- Once the patient is standing, pivot him toward the chair taking small steps. DO NOT TWIST.

- Bend your knees and lower the participant to the chair. The participant can hold onto your waist or shoulders but not your neck.

Staying Fit:

Keeping in shape is one of the best prevention strategies for protecting your back. Fitness involves:

- Aerobic activity (brisk walking, running, swimming, etc.). 20 minutes, 3x weekly
- Muscle strengthening (sit-ups, leg squats, lifting weights, etc)
- Flexibility exercises (yoga, stretching)

It is best to consult your physician before taking on new activities, especially if you have had previous injuries.

As a provider of home care you are at risk for back injury due to lifting and transferring. ACT wisely to avoid back injury and maintain your fitness. Using lifting devices and maintaining good posture will also help you at your own home.

Slips, Trips and Falls

The number one leading cause of injury are slips, trips and falls. Injuries are caused by:

- Wet floors or other slippery services (be very careful on ice!)
- Debris
- Loose carpets
- Throw rugs
- Electrical cords
- Poor lighting or glare from lighting
- Small dogs in the home

These are also hazards for participants and ways to improve safety in the home should be discussed.

To avoid injury:

- Watch where you are going
- Take your time and do not rush
- Keep your knees slightly bent
- Take shorter steps
- Wear supportive shoes
- Remove hazards when possible

Assessing the environment, removing hazards and proceeding cautiously when conditions are not ideal is the best way to prevent slips, trips and falls for yourself and the participant.

Infectious Diseases (Infectious Disease Control Center reference)

An infectious disease or communicable disease is caused by a biological agent such as by a virus, bacterium or parasite. Infectious diseases are the invasion of a host organism (human) by a foreign replicator, generally microorganisms, often called **microbes** that are invisible to the naked eye.

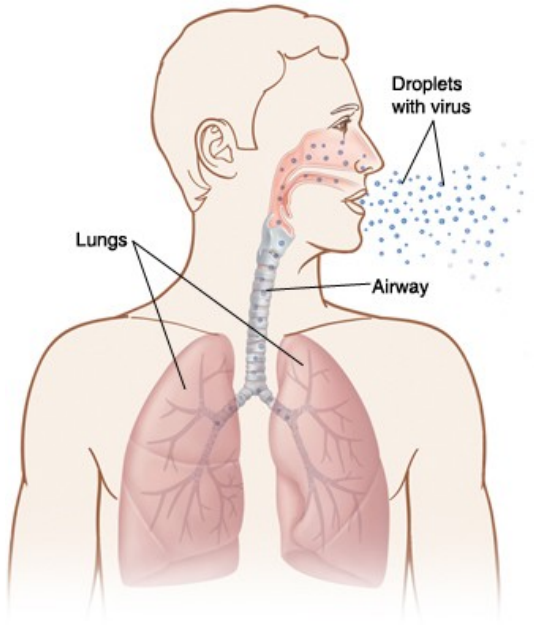
Microbes that cause illness are also known as pathogens. The most common pathogens are various **bacteria** and **viruses**, though a number of other microorganisms, including some kinds of **fungi** and **protozoa**, also cause disease. An infectious disease is termed *contagious* if it is easily transmitted from one person to another.

The common viruses that caregivers may be exposed to are discussed below:

Influenza

Influenza ("the flu") is an infection that affects the respiratory tract (the mouth, nose, and lungs, and the passages between them). Unlike a cold, the flu can make a person very ill. And it can lead to pneumonia, a serious lung infection. For some people, especially older adults, young children, and people with certain chronic conditions, the flu can have serious complications and even be fatal.

What Are the Risk Factors for the Flu?



Viruses that cause influenza spread through the air in droplets when someone who has the flu coughs, sneezes, laughs, or talks.

Anyone can get the flu. But you're more likely to become infected if the person:

- Has a weakened immune system.
- Works in a health care setting where you they be exposed to flu germs.
- Lives or works with someone who has the flu.
- Hasn't received an annual flu shot.

How Does the Flu Spread?

The flu is caused by viruses. The viruses spread through the air in droplets when someone who has the flu coughs, sneezes, laughs, or talks. People can become infected when they inhale these viruses directly. They also become infected when you touch a surface on which the droplets have landed and then transfer the germs to their eyes, nose, or mouth. Touching used tissues, or sharing utensils, drinking glasses, or a toothbrush with an infected person can expose a person to flu viruses, too.

What Are the Symptoms of the Flu?

Flu symptoms tend to come on quickly and may last a few days to a few weeks. They include:

- Fever usually higher than 101°F (38.3°C) and chills
- Sore throat and headache
- Dry cough
- Runny nose
- Tiredness and weakness
- Muscle aches

Factors That Can Make Flu Worse

For some people, the flu can be very serious. The risk of complications is greater for:

- Children under age 5.
- Adults 65 years of age and older.
- People with a chronic illness, such as diabetes or heart, kidney, or lung disease.
- People who live in a nursing home or long-term care facility.

How Is the Flu Treated?

Influenza usually improves after 7 days or so. In some cases, the person's health care provider may prescribe an antiviral medication. This may help the person get well sooner. For the medication to help, the person needs to take it as soon as possible (ideally within 48

hours) after your symptoms start. If the person develops pneumonia or other serious illness, hospital care may be needed.

Easing Flu Symptoms

- Drink lots of fluids such as water, juice, and warm soup. A good rule is to drink enough so that the person urinates your normal amount.
- Get plenty of rest.
- Ask the health care provider what to take for fever and pain.
- Call the provider if your fever rises over 101°F (38.3°C) or the person becomes dizzy, lightheaded, or short of breath.

Taking Steps to Protect Others

- Wash your hands often, especially after coughing or sneezing. Or, clean your hands with an alcohol-based hand cleaner containing at least 60 percent alcohol.
- Cough or sneeze into a tissue. Then throw the tissue away and wash your hands. If you don't have a tissue, cough and sneeze into the crook of your elbow.
- Stay home until at least 24 hours after you no longer have a fever or chills. Be sure the fever isn't being hidden by fever-reducing medication.
- Don't share food, utensils, drinking glasses, or a toothbrush with others.
- Ask your health care provider if others in your household should receive antiviral medication to help them avoid infection.

How Can the Flu Be Prevented?

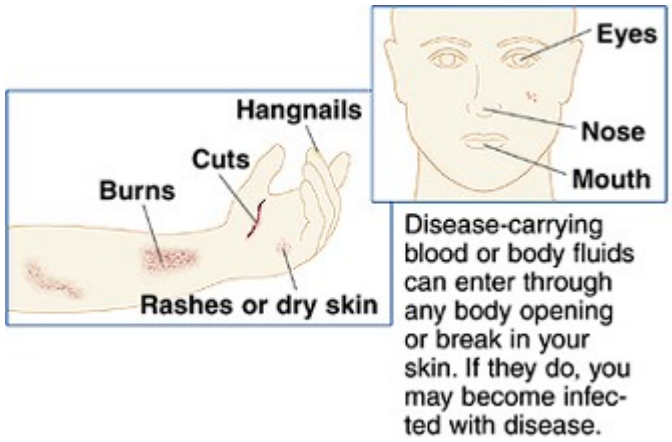
- One of the best ways to avoid the flu is to get a flu vaccination each year. Viruses that cause the flu change from year to year. For that reason, doctors recommend getting the flu vaccine each year, as soon as it's available in your area. The vaccine may be given as a shot or as a nasal spray. Your health care provider can tell you which vaccine is right for you.
- Wash your hands often. Frequent handwashing is a proven way to help prevent infection.
- Carry an alcohol-based hand gel containing at least 60 percent alcohol. Use it when you don't have access to soap and water. Then wash your hands as soon as you can.

- Avoid touching your eyes, nose, and mouth.
- At home and work, clean phones, computer keyboards, and toys often with disinfectant wipes.

If possible, avoid close contact with others who have the flu or symptoms of the flu.

Understanding Bloodborne Pathogens

Blood or body fluids may contain pathogens (germs) that can cause disease. If there is an accident at work involving blood or body fluids, these germs can be spread. The most common and serious bloodborne pathogens are the **hepatitis B virus (HBV), hepatitis C virus (HCV),** and **human immunodeficiency virus (HIV).** Once these germs infect a person may become sick. In turn, the germs may spread to others. The 3 bloodborne germs described below are the most common causes of infections in the workplace.



Hepatitis B virus (HBV)

- Hepatitis B can cause severe damage to the liver and can even lead to death.
- A vaccine is available to help prevent hepatitis B infection. This vaccine is given as 3 injections over a period of time.
- Adults who aren't vaccinated and are exposed at work to another person's blood or body fluids can be given medicine or a vaccine after the exposure. This helps prevent infection from developing.

Hepatitis C virus (HCV)

- Like hepatitis B, hepatitis C can cause severe damage to the liver and can lead to death.
- There is no known vaccine for HCV.

Human immunodeficiency virus (HIV)

- HIV makes it harder for the body to fight infection. HIV causes **acquired immune deficiency syndrome (AIDS),** which is a serious illness that can lead to death.
- There is no known vaccine for HIV.

How you could get infected at work

Bloodborne diseases can infect you when:

- You help an injured person without using a protective barrier between you and the infected person's blood or body fluids.
- An object or surface with infected blood or body fluids on it touches your broken skin.
- Contaminated body fluids on your unwashed hands come in contact with your eyes, nose, or mouth.
- You are pricked or scratched by a sharp object (such as broken glass, or a needle) that has infected blood or body fluids on it.

Universal Precautions (Primary Home Care reference)

Practices issued by the CDC (Center For Disease Control) in 1987 to reduce the spread of AIDS, Hepatitis B and other infections we may not even know of from one person to another, especially people who take care of other people.

Universal Precautions are rules about how you protect yourself from touching the bodily fluids from another person. This is important, because bodily fluids are how diseases like Hepatitis and AIDS are transmitted to another person.

When to Use them?
The rule is to ALWAYS use the Universal Precautions, because you often have no way of knowing if a person has a life threatening disease that you could catch.

Why Are Universal Precautions Important?
You are taking care of someone who may have chronic (ongoing) illnesses, or who may be contagious (as in the case of the flu) meaning you could “catch” what they have.

WEAR GLOVES: By gloves we mean latex or vinyl hand protection. They can be bought at most pharmacies. Gloves **MUST** be worn anytime you **MAY** come into contact with blood, body fluids, or mucous membranes. Case Managers for Participants may help supply gloves.

Example of when to wear gloves would include helping client blow nose or use the toilet.

Wash your hands or use hand sanitizer before you put on gloves…and of course after you remove them!

You should also wear gloves when:

- To cover your hands if you have cuts, scrapes or broken skin
- There is possible contact with soiled linen, feces, vomit, dressings or wound drainage, or you need to touch soiled clothing.

How to Safely Remove Gloves

1. Remove a glove by grasping it below the cuff—and pulling it off, while wearing the other glove….do not touch your bare skin.
2. Pull the glove down over your hand so it is inside out.
3. Hold the glove you removed with the other glove.
4. Reach inside the other glove and pull it down over the first glove.
5. Discard gloves and wash your hands. This process can be confusing at first, if you have any questions ask us!

Review

Wearing gloves is your best protection against bloodborne pathogens. They are to be worn anytime a worker may come into contact with bodily fluids of another person. Gloves are a barrier between YOU and the potentially infected client and will help prevent the spread of viruses.

Universal precautions were developed in 1987 to prevent the further spread of the AIDS virus, and also Hepatitis. Today, they prevent us from contracting these and other unknown diseases.

Remember: Hands and any other part of your body which comes into contact with blood or bodily fluids MUST be washed immediately. Wash your hands completely after removing and disposing of your gloves. If you work with more than one participant, wash your hands after finishing work with each.

NOTE: *Use clean gloves for each task, or set of related tasks.*

MANAGING SHARPS: If you are working with someone who is diabetic or takes injectable medication, DISPOSE OF SHARPS PROPERLY. IF THERE IS NO SHARPS DISPENSER AT THE HOME, MAKE ONE USING AN EMPTY METAL COFFEE CAN WITH A TIGHT FITTING LID, OR PLASTIC MILK JUG W/CAP.

Do not touch a client's skin if they have open wounds or lesions.

If you are shaving the individual or brushing his/her teeth, be very careful not to nick them, and avoid touching the cut.

Caregiver's Role:
Other things you can do:

- Double glove if you suspect a person is infected with hepatitis, HIV or AIDS.
- Properly dispose of sharps
- Always be aware of your surroundings, and what you come into contact with.
- It is important exercise, eat right and get good sleep to keep your immunity strong so you do not get sick and pass on illness to those you are working with.

HANDWASHING

Germs are everywhere around us. Normally, we live with germs without getting sick. In certain circumstances, harmful germs cause us to get sick with an infection. We also can spread harmful germs to others and cause them to get sick. Keeping your hands clean is the best way to prevent getting or spreading germs that cause infection. Wash your hands with soap and water or use an alcohol-based hand cleaner.

When to Clean Your Hands

It is easy to come into contact with many harmful germs. To help prevent infection, wash your hands often, especially:

- After using the bathroom
- Before and after eating
- After coughing or sneezing

- After using a tissue
- After touching or changing a dressing or bandage
- After touching any object or surface that may be contaminated
- After contact with blood or body fluids
- After touching or changing the person's bed linens or towels
- After removing protective gloves

Tips for Good Handwashing

Steps for Washing Hands:

- Use warm water and plenty of soap. Work up a good lather.
- Clean the whole hand, under your nails, between your fingers, and up the wrists.
- Wash for at least 20 seconds to 30 seconds. Don't just wipe. Scrub well (Sing Happy Birthday or recite the Alphabet).
- Rinse, letting the water run down your fingers, not up your wrists.
- Dry your hands well. Use a paper towel to turn off the faucet and open the door.

Steps for using Hand Sanitizers:

Alcohol-based hand cleaners may kill more germs than soap and water. Use them when your hands aren't visibly dirty. You do not want to overuse using sanitizers though because some amount of germs help your defense. For best results, follow these steps:

- Choose a gel or spray that contains at least 60 percent alcohol. Products with less alcohol may not kill germs.
- Spread about a tablespoon of cleaner in the palm of one hand.
- Rub your hands together briskly, cleaning the backs of your hands, the palms, between your fingers, and up the wrists.
- Rub until the cleaner is gone, and your hands are completely

CONCLUSION: You are considered a health care provider and work with vulnerable adults and children who are may have or are more susceptible to infectious diseases, trips and falls and need assistance with moving. Please follow the prevention ideas in this Handbook to protect yourself and the person you serve from injury and viruses.