



Welcome! It is a pleasure to have you apply with us here at Home Guardian Angels Inc.

Please review and return the following documents:

- Employment Application
- Home Health Care Aide Registration (HCS 100 7/23)
- SOC 341A- Requirement to Report Suspected Abuse
- LIC 508- Criminal Record Statement
- HCA 501- Personnel Record Form
- W-4- Federal Withholding Form
- DE-4 CA Withholding Form
- Direct Deposit Form
- Form 8850 Pre-Screening Notice and Certification Request WOCT
- ETA Form 9061- WOTC (Payroll Form)
- Tuberculous (TB) Test Notice
- Employee Tuberculous (TB) Records- **Completed within 2 weeks of Onboarding**
- Tuberculous (TB) Risk Assessment- **Completed by Medical Provider**

Once we receive the documents listed above, our team will reach out to you to schedule the retrieval of your badge and finalize your new hire onboarding on-site.

At that time, please have the following identification and documentation available:

Certification Documents:

- First Aid & CPR certification
- TB Test Results
- HHA or IHSS (orientation attendance) certificate

Once again, thank you for your interest in employment with our organization. We look forward to a productive future working together to serve our communities.

Sincerely,

Marc Adderly



APPLICATION FOR EMPLOYMENT

Name _____ Date _____
Last First Middle

Address _____
Street City State/Province ZIP/Postal Code

Telephone # (_____) _____ Cell Phone # (_____) _____

E-Mail address _____ Referred to us by _____

Position(s) applied for Caregiver/HCA Nurse Other: _____ Date Available: _____

Type of employment desired Full-Time
 Part-Time Casual Please Specify Days and Hours _____

If currently employed, may we contact your employer? Yes No

Rate of Pay Expected \$ _____ per hour

What motivates you to seek employment with our company?
Please provide a brief explanation:

Are you legally authorized to work in the United States? Yes No

Are you available to work overtime if required? Yes No

Have you applied with this company before? Yes No

Have you been employed at this company before? Yes No

If yes, when? _____ and at what location? _____

Do you have any friends or family employed at this location? Yes No

If considered for hiring, will you agree to provide a criminal background check? Yes No

If considered for hiring, will you agree to provide a drivers abstract? Yes No N.A.

EDUCATIONAL BACKGROUND

List previous three (3) educational institutions attended, beginning with the most recent.

SCHOOL	CITY, STATE/PROVINCE	GRADUATED?	DEGREE(S)/DIPLOMA(S) EARNED
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

What Nursing or relevant designations, licenses or registrations if any, do you possess?

Type	Date of Most Recent Registration	Valid in State/Province?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have the following: CPR No Yes - Last Certified _____
 First Aid No Yes - Last Certified _____

EMPLOYMENT BACKGROUND

Provide the following information beginning with the most recent employer.

EMPLOYER	TELEPHONE ()	DATES EMPLOYED		SUMMARIZE THE TYPE OF WORK PERFORMED AND JOB RESPONSIBILITIES
		FROM	TO	
ADDRESS				
JOB TITLE				
IMMEDIATE SUPERVISOR AND TITLE AND PHONE NUMBER				
REASON FOR LEAVING				
MAY WE CONTACT FOR REFERENCE? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later				
EMPLOYER	TELEPHONE ()	DATES EMPLOYED		SUMMARIZE THE TYPE OF WORK PERFORMED AND JOB RESPONSIBILITIES
ADDRESS		FROM	TO	
JOB TITLE				
IMMEDIATE SUPERVISOR AND TITLE AND PHONE NUMBER				
REASON FOR LEAVING				
MAY WE CONTACT FOR REFERENCE? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later				

EMERGENCY CONTACT / PERSONAL REFERENCES

List the name, relationship, number of years acquainted, and phone number of emergency contact and two references. (No relatives please).

NAME	RELATIONSHIP	YEARS ACQUAINTED	PHONE NUMBER
			()
			()
			()

To the best of my knowledge, I certify that the information in this application is true and accurate.

I understand that any false statements or omissions may result in rejection of my application or immediate termination of employment, regardless of when discovered. I authorize this company to investigate all statements contained in this application. I acknowledge that I have personally completed this application or have indicated the name of the individual who assisted me. The information provided in this application, along with any attached resume, is strictly confidential and will not be shared with any third parties. The employer solely uses this information to evaluate candidates for employment. By signing this application, the applicant consents to the collection and use of the provided information for the specified purposes.

The applicant acknowledges that nothing stated in this application or during any interview process shall constitute an employment contract between themselves and Home Guardian Angels Inc. If employed, the applicant understands that either party has the right to terminate their employment at any time, with or without cause. Any contrary promises or representations are non-binding unless made in writing and signed by both parties.

I understand that if hired, I will need to provide proof of identity and legal authorization to work in the United States, proof of certifications or educational qualifications, and a driver's abstract (if applicable).

Home Guardian Angels Inc. is an equal opportunity employer and is committed to providing equal employment opportunities to all qualified individuals without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, genetic information, or veteran status. The applicant further acknowledges that Home Guardian Angel Inc. adheres to the Drug-Free Workplace Act of 1988.

Applicant's Signature _____ **Date** _____

For office use only:

Date application received: _____

Date applicant contacted: _____

Notes: _____

A 1 2 3 4 5 6 7 8 9 10

C 1 2 3 4 5 6 7 8 9 10

F 1 2 3 4 5 6 7 8 9 10

APPLICATION FOR HOME CARE AIDE REGISTRATION OR RENEWAL

Please type or print clearly. Mail this completed two-page application and the materials specified below to: California Department of Social Services, Home Care Services Bureau, 744 P Street, MS 9-14-90, Sacramento, CA 95814. You can also apply online at Guardian.dss.ca.gov/applicant. **Per Health and Safety Code Section 1796.48, the Home Care Aide initial application and renewal application fee is nonrefundable.**

APPLICATION TYPE: (check one)

Initial Application:

- Application for Home Care Aide Registration or Renewal (HCS 100)
- Check or money order for \$35.00, payable to the California Department of Social Services
When fingerprinting, a Request for Live Scan Service – Community Care Licensing form (LIC 9163) must be completed and submitted to the Live Scan operator.

Renewal Application:

- Application for Home Care Aide Registration or Renewal (HCS 100)
- Check or money order for \$35.00, payable to the California Department of Social Services
If renewing your registration, the application and fee must be postmarked or submitted on or before your expiration date or your registration will be forfeited.

Required Information

NAME			DATE OF BIRTH
Last:	First:	Middle	
MAILING ADDRESS			
Street Address/P.O. Box:			Apt:
City:	State:	Zip Code:	

Voluntary Information

The following fields are optional but omission may delay the processing of your application.

ALIASES (AKAs/MAIDEN) OR OTHER NAMES EVER USED	PER ID/HCA ID (if applicable)
RESIDENCE ADDRESS	
Street Address:	Apt:
City:	State:
	Zip Code:
EMAIL ADDRESS	TELEPHONE NUMBER
	SOCIAL SECURITY NUMBER

IDENTIFICATION

Document Type: (check one)

- Valid California Driver’s License
- Valid California Identification Card issued by the Department of Motor Vehicles
- Valid Permanent Resident Card
- For a person living in a state other than California, a Valid Numbered Photo Identification Card issued by a state agency other than California (Issuing State: _____)

Document Number:	Expiration Date (if applicable):
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Disclosure of Personal Information and Opt-Out Information

Health and Safety Code Section 1796.29 requires the California Department of Social Services (CDSS) to provide an electronic copy of a Registered Home Care Aide’s name, telephone number, and cellular telephone number (contact information) to a labor organization upon request. The labor organization shall not use this information for any purpose other than employee organizing, representation, and assistance activities, and shall not disclose this information to any other party. A Registered Home Care Aide or Home Care Aide applicant may opt-out of sharing their contact information with labor organizations. If you do not want your contact information provided to labor organizations, please check the box below.

I wish to opt-out. I do not want my contact information provided to labor organizations.

REGISTERED HOME CARE AIDE APPLICANT REQUIREMENTS

- Registered home care aides and home care aide applicants must notify CDSS of a new mailing address within 10 days. (Health and Safety Code §1796.28(a)(2),)
- You must be 18 years of age or older to apply or be a Registered Home Care Aide listed on the Home Care Aide Registry. (Health and Safety Code §1796.21.)
- You must not have had a criminal record exemption denied within the past two years. (Health and Safety Code §1796.26(a)(3).)
- Your application may be denied or your registration may be revoked if:
 - the Department of Social Services or a county had previously revoked or rescinded your license or certificate to be a certified family home or resource family, a certified administrator, or a registered TrustLine provider, or if CDSS had excluded you from a licensed facility, certified family home, or resource family home. (Health and Safety Code §1795.25(a)(3).)
 - the Department of Social Services or a county had previously denied your application for a license from CDSS or certificate to be a certified family home or resource family, a certified administrator, or a registered TrustLine provider. (Health and Safety Code §1795.25(a)(4).)

I DECLARE UNDER PENALTY OF PERJURY THAT THE STATEMENTS ON THIS FORM ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature	Date
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PRIVACY NOTICE

As Required by Civil Code §1798.17

Collection and Use of Personal Information. The California Justice Information Services (CJIS) Division in the Department of Justice (DOJ) and the Care Provider Management Bureau (CPMB) in CDSS collect the information requested on this form as authorized by Penal Code sections 11100-11112; Health and Safety Code sections 1796.22, 1796.23, 1522, 1522.1, and other state statutes and regulations. The CJIS Division uses this information to process requests of authorized entities that want to obtain information as to the existence and content of a record of state or federal convictions to help determine suitability for the purposes of becoming or continuing to be a Registered Home Care Aide. In addition, any personal information collected by state agencies is subject to the limitations in the Information Practices Act and state policy. The DOJ's general privacy policy is available on the [DOJ Privacy Policy Statement](https://oag.ca.gov/privacy-policy) webpage (<https://oag.ca.gov/privacy-policy>).

Providing Personal Information. All personal information requested in the form must be provided with the exception of a Social Security Number (SSN) Federal law (at Title 5 United States Code Section 552a Note) states that: Any federal, state, or local government agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it.

Important: Failure to provide all the required information on this form will result in delays and/or the rejection of your request. Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code sections 1798 et seq.) notice is given for the request of your Social Security Number (SSN) on this form. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal background check.

Access to Your Information. You may review the records maintained by the CJIS Division in the DOJ that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

Possible Disclosure of Personal Information. In order to be a Registered Home Care Aide, the law requires that you complete a criminal background check. (Health and Safety Code sections 1796.23 and 1522). CDSS will create a file concerning your criminal background check that will contain certain documents, including personal information that you provide. You have the right to access certain records containing your personal information maintained by CDSS (Civil Code section 1798 et seq.).

IMPORTANT INFORMATION

Under the California Public Records Act (Government Code section 7920.000 et seq.) and Health and Safety Code section 1796.29, CDSS may provide copies of a Registered Home Care Aide's home care aide number to members of the public who ask for them, including newspaper and television reporters (news media).

The information you provide may also be disclosed in the following circumstances:

- To other persons or agencies where disclosure is necessary for them to perform their legal duties, and their use of your information is compatible and complies with the law, such as for investigations or for licensing, certification, or regulatory purposes.
- To a labor union, if you did not opt-out of sharing your contact information pursuant to Health and Safety Code section 1796.29 (see Opt-Out Information on page 2 of this form).
- To another government agency as required by state or federal law.

QUESTIONS ABOUT NOTICE AND RECORD INFORMATION

For questions about this notice, the Home Care Aide Registry, and the authorized use of your criminal history information, please contact the Home Care Services Bureau.

California Department of Social Services
Home Care Services Bureau
744 P Street, MS 9-14-90
Sacramento, CA 95814

For further questions about criminal records, you may contact the Associate Governmental Program Analyst at the DOJ's Keeper of Records at (916) 210-3310, by email at keeperofrecords@doj.ca.gov, or by mail at:

Department of Justice
Bureau of Criminal Information & Analysis Keeper of Records
P.O. Box 903417
Sacramento, CA 94203-4170

Applicant Notification and Record Challenge

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to complete or challenge the accuracy of the information contained in the FBI identification record. The procedure for obtaining a change, correction, or updating an FBI identification record are set forth in Title 28, Code of Federal Regulations (CFR), 16.34. You can find additional information on the [FBI Identity History Summary Checks](https://www.fbi.gov/services/cjis/identity-history-summary-checks) webpage (<https://www.fbi.gov/services/cjis/identity-history-summary-checks>).

Federal Privacy Act Statement

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 United States Code (U.S.C.) 534. Depending on the nature of your application, supplemental authorities include federal statutes, state statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine Uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing,

security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

Noncriminal Justice Applicant's Privacy Rights: As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below.

- You must be provided written notification¹ that your fingerprints will be used to check the criminal history records of the FBI.
- You must be provided, and acknowledge receipt of, an adequate Privacy Act Statement when you submit your fingerprints and associated personal information. This Privacy Act Statement should explain the authority for collecting your information and how your information will be used, retained, and shared (<https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement>).
- If you have a criminal history record, the officials making a determination of your suitability for the employment, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The officials must advise you that the procedures for obtaining a change, correction, or update of your criminal history record are set forth at Title 28 CFR section 16.34.
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the criminal history record.²

You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.³

If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit providing you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained on the [FBI Identity History Summary Checks](https://www.fbi.gov/services/cjis/identity-history-summary-checks) webpage (<https://www.fbi.gov/services/cjis/identity-history-summary-checks>).

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.) You can find additional information on the [FBI Identity History Summary Checks](https://www.fbi.gov/services/cjis/identity-history-summary-checks) webpage (<https://www.fbi.gov/services/cjis/identity-history-summary-checks>).

1 Written notification includes electronic notification, but excludes oral notification.

2 See 28 CFR 50.12(b)

3 See U.S.C. 552a(b); 28 U.S.C. 534(b); 34 U.S.C. § 40316 (formerly cited as 42 U.S.C. § 14616), Article IV(c)

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT SUSPECTED ABUSE OF DEPENDENT ADULTS AND ELDERS

NOTE: RETAIN IN EMPLOYEE/ VOLUNTEER FILE

NAME

POSITION

FACILITY

California law **REQUIRES** certain persons to report known or suspected abuse of dependent adults or elders. As an employee or volunteer at a licensed facility, you are one of those persons - a “mandated reporter.”

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include care custodians and any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not paid for that responsibility (Welfare and Institutions Code (WIC) Section 15630(a)). **Care custodian** means an administrator or an employee of most public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff (WIC Section 15610.17).

PERSONS WHO ARE THE SUBJECT OF THE REPORT

Elder means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **Dependent Adult** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age and those admitted as inpatients in 24-hour health facilities (WIC Section 15610.23).

REPORTING RESPONSIBILITIES AND TIME FRAMES

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect occurred, shall complete form SOC 341, “Report of Suspected Dependent Adult/Elder Abuse” for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult.

Reporting shall be completed as follows:

- If the abuse occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) and resulted in serious bodily injury (as defined in WIC Section 15610.67), report by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California

Department of Social Services) within two (2) hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, but did not result in serious bodily injury, report by telephone to the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local LTCOP, and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, was physical abuse, did not result in serious bodily injury, and was perpetrated by a resident with a physician's diagnosis of dementia, report by telephone to the local law enforcement agency or the local LTCOP, immediately or as soon as practicably possible. Follow by sending the written report to the LTCOP or the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.
- If the abuse occurred in a LTC facility, and was abuse other than physical abuse, report by telephone to the LTCOP or the law enforcement agency immediately or as soon as practicably possible. Follow by sending the written report to the local law enforcement agency or the LTCOP within two working days.
- If the abuse occurred in a state mental hospital or a state developmental center, mandated reporters shall report by telephone or through a confidential internet reporting tool (established in WIC Section 15658) immediately or as soon as practicably possible and submit the report within two (2) working days of making the telephone report to the responsible agency as identified below:
 - If the abuse occurred in a State Mental Hospital, report to the local law enforcement agency or the California Department of State Hospitals.
 - If the abuse occurred in a State Developmental Center, report to the local law enforcement agency or to the California Department of Developmental Services.
- For all other abuse, mandated reporters shall report by telephone or through a confidential internet reporting tool to the adult protective services agency or the local law enforcement agency immediately or as soon as practicably possible. If reported by telephone, a written or an Internet report shall be sent to adult protective services or law enforcement within two working days.

PENALTY FOR FAILURE TO REPORT ABUSE

Failure to report abuse of an elder or dependent adult is a MISDEMEANOR CRIME, punishable by jail time, fine or both (WIC Section 15630(h)). The reporting duties are individual, and no supervisor or administrator shall impede or inhibit the reporting duties, and no person making the report shall be subject to any sanction for making the report (WIC Section 15630(f)).

CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only

among APS agencies, local law enforcement agencies, LTCOPs, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order. Any violation of confidentiality is a misdemeanor punishable by jail time, fine, or both (WIC Section 15633(a)).

DEFINITIONS OF ABUSE

Physical abuse means any of the following: (a) Assault, as defined in Section 240 of the Penal Code; (b) Battery, as defined in Section 242 of the Penal Code; (c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code; (d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water; (e) Sexual assault, that means any of the following: (1) Sexual battery, as defined in Section 243.4 of the Penal Code; (2) Rape, as defined in Section 261 of the Penal Code; (3) Rape in concert, as described in Section 264.1 of the Penal Code; (4) Spousal rape, as defined in Section 262 of the Penal Code; (5) Incest, as defined in Section 285 of the Penal Code; (6) Sodomy, as defined in Section 286 of the Penal Code; (7) Oral copulation, as defined in Section 288a of the Penal Code; (8) Sexual penetration, as defined in Section 289 of the Penal Code; or (9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code; or (f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions: (1) For punishment; (2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given; or (3) For any purpose not authorized by the physician and surgeon (WIC Section 15610.63).

Serious bodily injury means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation (WIC Section 15610.67).

Neglect (a) means either of the following: (1) The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise; or (2) The negligent failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise. (b) Neglect includes, but is not limited to, all of the following: (1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter; (2) Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment; (3) Failure to protect from health and safety hazards; (4) Failure to prevent malnutrition or dehydration; or (5) Failure of an elder or dependent adult to satisfy the needs specified in paragraphs (1) to (4), inclusive, for himself or herself as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health (WIC Section 15610.57).

Financial abuse of an elder or dependent adult occurs when a person or entity does any of the following: (1) Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; (2) Assists in taking, secreting, appropriating, obtaining, or retaining real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; or (3) Takes, secretes, appropriates, obtains, or

retains, or assists in taking, secreting, appropriating, obtaining, or retaining, real or personal property of an elder or dependent adult by undue influence, as defined in Section 15610.70 (WIC Section 15610.30(a)).

Abandonment means the desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody (WIC Section 15610.05).

Isolation means any of the following: (1) Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls; (2) Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons; (3) False imprisonment, as defined in Section 236 of the Penal Code; or (4) Physical restraint of an elder or dependent adult, for the purpose of preventing the elder or dependent adult from meeting with visitors (WIC Section 15610.43).

Abduction means the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, of any elder or dependent adult who does not have the capacity to consent to the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, as well as the removal from this state or the restraint from returning to this state, of any conservatee without the consent of the conservator or the court (WIC Section 15610.06).

AS AN EMPLOYEE OR VOLUNTEER OF THIS FACILITY, YOU MUST COMPLY WITH THE DEPENDENT ADULT AND ELDER ABUSE REQUIREMENTS, AS STATED ABOVE. IF YOU DO NOT COMPLY, YOU MAY BE SUBJECT TO CRIMINAL PENALTY. IF YOU ARE A LONG-TERM CARE OMBUDSMAN, YOU MUST COMPLY WITH FEDERAL AND STATE LAWS, WHICH PROHIBIT YOU FROM DISCLOSING THE IDENTITIES OF LONG-TERM RESIDENTS AND COMPLAINANTS TO ANYONE UNLESS CONSENT TO DISCLOSE IS PROVIDED BY THE RESIDENT OR COMPLAINANT OR DISCLOSURE IS REQUIRED BY COURT ORDER (Title 42 United States Code Section 3058g(d)(2); WIC Section 9725).

I, _____, have read and understand my responsibility to report known or suspected abuse of dependent adults or elders. I will comply with the reporting requirements.

SIGNATURE

DATE

CRIMINAL RECORD STATEMENT

State law requires that persons associated with licensed facilities or Home Care Aide Registry applicants be fingerprinted and disclose any conviction. A conviction is any plea of guilty or nolo contendere (no contest) or a verdict of guilty. The fingerprints will be used to obtain a copy of any criminal history you may have.

Have you ever been convicted of a crime in California ? **YES** **NO**

You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.

Have you ever been convicted of a crime from another state, federal court, military or jurisdiction outside of U.S.? **YES** **NO**

Criminal convictions from another State or Federal court are considered the same as criminal convictions in California.

If you answer YES, give details on the back of this page indicating the nature and circumstances of each crime and the date and the location in which each crime occurred.

You must disclose convictions, including reckless and drunk driving convictions even if:

1. It happened a long time ago;
2. It was only a misdemeanor;
3. You didn't have to go to court (your attorney went for you);
4. You had no jail time or the sentence was only a fine or probation;
5. You received a certificate of rehabilitation;
6. The conviction was later dismissed, set aside or the sentence was suspended.

NOTE: IF THE CRIMINAL BACKGROUND CHECK REVEALS ANY CONVICTION(S) THAT YOU DID NOT DISCLOSE ON THIS FORM, YOUR FAILURE TO DISCLOSE THE CONVICTION(S) WILL RESULT IN AN EXEMPTION DENIAL, LICENSE APPLICATION DENIAL, LICENSE REVOCATION, OR EXCLUSION FROM A LICENSED FACILITY/ORGANIZATION.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses and any accompanying attachments are true and correct.			
FACILITY/ORGANIZATION NAME		FACILITY/ORGANIZATION NUMBER	
YOUR NAME (<i>PRINT CLEARLY</i>)	YOUR ADDRESS	CITY	ZIP
SOCIAL SECURITY NUMBER <small>(SEE PRIVACY STATEMENT ON REVERSE SIDE)</small>	DATE OF BIRTH	DMV LICENSE NUMBER	
SIGNATURE		DATE	

I. Instructions to Respondents:

If you have been convicted of a crime in California, another state or in federal court, provide the following information:

(You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.)

What was the offense? _____

In which state and city did you commit the offense? _____

When did this occur? _____

Tell us what happened. (Use additional sheets of paper if needed) _____

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge.

Signature _____ **Date** _____

II. Instructions to Licensees:

If the person discloses a criminal conviction, review the person’s statement and discuss it with your Licensing Program Analyst (LPA). Maintain this form in your facility/organization personnel file and send a copy to your LPA.

PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person’s SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility/organization, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17, 1596.871, and 1796.19). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

NOTE: IMPORTANT INFORMATION

The Department is required to tell people who ask, including the press, if someone in a licensed facility/organization has a criminal record exemption. The Department must also tell people who ask, the name of a licensed facility/organization that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

PERSONNEL RECORD

(Form to be Completed by employee at the time of hire)

FOR HOME CARE ORGANIZATION USE ONLY
NAME OF HOME CARE ORGANIZATION
HOME CARE ORGANIZATION ADDRESS
HOME CARE ORGANIZATION NUMBER
DATE OF EMPLOYMENT
DATE OF SEPARATION

PERSONAL

NAME (LAST FIRST MIDDLE)	AREA CODE/TELEPHONE ()
ADDRESS	DATE OF BIRTH
SOCIAL SECURITY NUMBER: (VOLUNTARY FOR ID ONLY)	DATE OF LAST TB TEST RESULTS OF LAST TB TEST
HAVE YOU EVER BEEN EMPLOYED UNDER A DIFFERENT NAME? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE LIST ALL NAMES USED.	
DO YOU POSSESS A VALID CALIFORNIA DRIVER'S LICENSE? <input type="checkbox"/> YES <input type="checkbox"/> NO CDL NUMBER: _____	

POSITION INFORMATION

TITLE OF POSITION	TIME BASE
-------------------	-----------

EMPLOYMENT

(List most recent experience first. If additional space is needed, please attach a separate page.)

NAME AND ADDRESS OF EMPLOYER	AREA CODE/ TELEPHONE	JOB TITLE AND TYPE OF WORK	REASON FOR LEAVING	DATES	
				FROM	TO
	()				
	()				
	()				
	()				
	()				

Notes:

I hereby certify under penalty of perjury that I am 18 years of age or older and that the above statements are true and correct.
 I give my permission for any necessary verification.

EMPLOYEE SIGNATURE	DATE
--------------------	------

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.

2024

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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

(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	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	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income		4(a) \$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here		4(b) \$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period		4(c) \$ _____

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	Employee's signature (This form is not valid unless you sign it.)		Date

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

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

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

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

The *California Employer's Guide (DE 44)* (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication may be found by visiting Payroll Taxes - Forms and Publications (edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm). To assist you in calculating your tax liability, please visit the Franchise Tax Board (FTB) (ftb.ca.gov).

If you need information on your last *California Resident Income Tax Return (FTB Form 540)*, visit the FTB (ftb.ca.gov).

Notification: The burden of proof rests with the employee to show the correct California income tax withholding. Pursuant to section 4340-1(e) of Title 22, California Code of Regulations (CCR) (govt.westlaw.com/calregs/Search/Index), the FTB or the EDD may, by special direction in writing, require an employer to submit a Form W-4 or DE 4 when such forms are necessary for the administration of the withholding tax programs.

Penalty: You may be fined \$500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided by section 13101 of the California Unemployment Insurance Code (leginfo.ca.gov/faces/codes.xhtml) and section 19176 of the Revenue and Taxation Code (leginfo.ca.gov/faces/codes.xhtml).

Worksheets

Instructions — 1 — Allowances*

When determining your withholding allowances, you must consider your personal situation:

- Do you claim allowances for dependents or blindness?
- Will you itemize your deductions?
- Do you have more than one income coming into the household?

Two-Earners/Multiple Incomes: When earnings are derived from more than one source, under-withholding may occur. If you have a working spouse or more than one job, it is best to check the box "SINGLE or MARRIED (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with **one** employer.

Do **not** claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 filed for the highest paying job and zero allowances are claimed for the others.

Married But Not Living With Your Spouse: You may check the "Head of Household" marital status box if you meet all of the following tests:

- (1) Your spouse will not live with you **at any time** during the year;
- (2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; **and**
- (3) You will file a separate return for the year.

Head of Household: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the **entire** year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

Worksheet A

Regular Withholding Allowances

(A) Allowance for yourself — enter 1	(A)
(B) Allowance for your spouse (if not separately claimed by your spouse) — enter 1	(B)
(C) Allowance for blindness — yourself — enter 1	(C)
(D) Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1	(D)
(E) Allowance(s) for dependent(s) — do not include yourself or your spouse	(E)
(F) Total — add lines (A) through (E) above and enter on line 1a of the DE 4	(F)

Instructions — 2 — (Optional) Additional Withholding Allowances

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim **one or more additional** withholding allowances. Use last year's FTB Form 540 as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments, or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each \$1,000, or fraction of \$1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

Worksheet B

Estimated Deductions

Use this worksheet **only** if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1. Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB Form 540	1.
2. Enter \$10,726 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or \$5,363 if single or married filing separately, dual income married, or married with multiple employers	– 2.
3. Subtract line 2 from line 1, enter difference	= 3.
4. Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+ 4.
5. Add line 4 to line 3, enter sum	= 5.
6. Enter an estimate of your nonwage income (dividends, interest income, alimony receipts)	– 6.
7. If line 5 is greater than line 6 (if less, see below [go to line 9]); Subtract line 6 from line 5, enter difference	= 7.
8. Divide the amount on line 7 by \$1,000, round any fraction to the nearest whole number enter this number on line 1b of the DE 4. Complete Worksheet C, if needed, otherwise stop here .	8.
9. If line 6 is greater than line 5; Enter amount from line 6 (nonwage income)	9.
10. Enter amount from line 5 (deductions)	10.
11. Subtract line 10 from line 9, enter difference. Then, complete Worksheet C.	11.

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California PIT withholding and PIT wages. This law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 1-888-745-3886.

Worksheet C

Additional Tax Withholding and Estimated Tax

1. Enter estimate of total wages for tax year 2024. 1.
2. Enter estimate of nonwage income (line 6 of Worksheet B). 2.
3. Add line 1 and line 2. Enter sum. 3.
4. Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest). 4.
5. Enter adjustments to income (line 4 of Worksheet B). 5.
6. Add line 4 and line 5. Enter sum. 6.
7. Subtract line 6 from line 3. Enter difference. 7.
8. Figure your tax liability for the amount on line 7 by using the 2024 tax rate schedules below. 8.
9. Enter personal exemptions (line F of Worksheet A x \$158.40). 9.
10. Subtract line 9 from line 8. Enter difference. 10.
11. Enter any tax credits. (See FTB Form 540). 11.
12. Subtract line 11 from line 10. Enter difference. This is your total tax liability. 12.
13. Calculate the tax withheld and estimated to be withheld during 2024. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2024. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2024. 13.
14. Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld. 14.
15. Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4. 15.

Note: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the "single" status with "zero" allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

These Tables Are for Calculating Worksheet C and for 2024 Only

**Single Persons, Dual Income Married
or Married With Multiple Employers**

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...	PLUS	
\$0	\$10,412	1.100%	\$0	\$0.00
\$10,412	\$24,684	2.200%	\$10,412	\$114.53
\$24,684	\$38,959	4.400%	\$24,684	\$428.51
\$38,959	\$54,081	6.600%	\$38,959	\$1,056.61
\$54,081	\$68,350	8.800%	\$54,081	\$2,054.66
\$68,350	\$349,137	10.230%	\$68,350	\$3,310.33
\$349,137	\$418,961	11.330%	\$349,137	\$32,034.84
\$418,961	\$698,271	12.430%	\$418,961	\$39,945.90
\$698,271	\$1,000,000	13.530%	\$698,271	\$74,664.13
\$1,000,000	and over	14.630%	\$1,000,000	\$115,488.06

Married Persons

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...	PLUS	
\$0	\$20,824	1.100%	\$0	\$0.00
\$20,824	\$49,368	2.200%	\$20,824	\$229.06
\$49,368	\$77,918	4.400%	\$49,368	\$857.03
\$77,918	\$108,162	6.600%	\$77,918	\$2,113.23
\$108,162	\$136,700	8.800%	\$108,162	\$4,109.33
\$136,700	\$698,274	10.230%	\$136,700	\$6,620.67
\$698,274	\$837,922	11.330%	\$698,274	\$64,069.69
\$837,922	\$1,000,000	12.430%	\$837,922	\$79,891.81
\$1,000,000	\$1,396,542	13.530%	\$1,000,000	\$100,038.11
\$1,396,542	and over	14.630%	\$1,396,542	\$153,690.24

Unmarried/Head of Household

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...	PLUS	
\$0	\$20,839	1.100%	\$0	\$0.00
\$20,839	\$49,371	2.200%	\$20,839	\$229.23
\$49,371	\$63,644	4.400%	\$49,371	\$856.93
\$63,644	\$78,765	6.600%	\$63,644	\$1,484.94
\$78,765	\$93,037	8.800%	\$78,765	\$2,482.93
\$93,037	\$474,824	10.230%	\$93,037	\$3,738.87
\$474,824	\$569,790	11.330%	\$474,824	\$42,795.68
\$569,790	\$949,649	12.430%	\$569,790	\$53,555.33
\$949,649	\$1,000,000	13.530%	\$949,649	\$100,771.80
\$1,000,000	and over	14.630%	\$1,000,000	\$107,584.29

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit [FTB](https://ftb.ca.gov) (ftb.ca.gov).

The DE 4 information is collected for purposes of administering the PIT law and under the authority of Title 22, CCR, section 4340-1, and the California Revenue and Taxation Code, including section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California resident income tax return.

Last Name First Name (Please Print Clearly)

Employee ID Number

I authorize Home Guardian Angels to Direct Deposit my regular payroll check and/or initiate, if necessary, debit entries and adjustments for any credit entries made in error to my account(s). **PLEASE NOTE: If for any reason your bank account(s) should change or be closed, it is YOUR RESPONSIBILITY to notify the Payroll Office.**

DIRECT DEPOSIT GENERAL INFORMATION

1. Direct Deposit will begin approximately two regular pay periods.
2. This authorization is to remain in force until the HR Department has received written authorization from me of its termination or change.

I HAVE READ, UNDERSTAND AND AGREE TO THE DIRECT DEPOSIT INFORMATION AS STATED IN THIS AGREEMENT:

SIGNATURE

DATE

ACCOUNT #1:

PLEASE CHECK ONE: New Change Use Previous Account Information in File
 Cancel (I hereby request direct deposit to stop immediately_____)
Initials

I WISH TO HAVE: 100% of my net pay Fixed amount of \$_____ (Per Pay Period)
 Remaining Balance

DEPOSITED TO MY: Checking Account (**Attach Voided Check**)
 Savings Account (**Attach statement from bank**)

BANK NAME

BANK PHONE NUMBER

ROUTING/TRANSIT (ABA)NUMBER

ACCOUNT NUMBER

ACCOUNT #2:

PLEASE CHECK ONE: New Change
 Cancel (I hereby request direct deposit to stop immediately_____)
Initials

I WISH TO HAVE: 100% of my net pay Fixed amount of \$_____ (Per Pay Period)
 Remaining Balance

DEPOSITED TO MY: Checking Account (**Attach Voided Check**)
 Savings Account (**Attach statement from bank**)

BANK NAME

BANK PHONE NUMBER

ROUTING/TRANSIT (ABA)NUMBER

ACCOUNT NUMBER

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

► Information about Form 8850 and its separate instructions is at www.irs.gov/form8850.

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name _____ Social security number ► _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

If you are under age 40, enter your date of birth (month, day, year) _____

- 1 Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

- 2 Check here if **any** of the following statements apply to you.
 - I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
 - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
 - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
 - I am at least age 18 but **not** age 40 or older and I am a member of a family that:
 - a. Received SNAP benefits (food stamps) for the past 6 months; **or**
 - b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
 - During the past year, I was convicted of a felony or released from prison for a felony.
 - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
 - I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

- 3 Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

- 4 Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

- 5 Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

- 6 Check here if you are a member of a family that:
 - Received TANF payments for at least the past 18 months; **or**
 - Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
 - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

- 7 Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ► _____

Date _____

For Employer's Use Only

Employer's name _____ Telephone no. _____ EIN ► _____

Street address _____

City or town, state, and ZIP code _____

Person to contact, if different from above _____ Telephone no. _____

Street address _____

City or town, state, and ZIP code _____

If, based on the individual's age and home address, he or she is a member of group 4 or 6 (as described under *Members of Targeted Groups* in the separate instructions), enter that group number (4 or 6) ► _____

Date applicant:

Gave information _____ Was offered job _____ Was hired _____ Started job _____

Under penalties of perjury, I declare that the applicant provided the information on this form on or before the day a job was offered to the applicant and that the information I have furnished is, to the best of my knowledge, true, correct, and complete. Based on the information the job applicant furnished on page 1, I believe the individual is a member of a targeted group. I hereby request a certification that the individual is a member of a targeted group.

Employer's signature ► _____ **Title** _____ **Date** _____

Privacy Act and Paperwork Reduction Act Notice

Section references are to the Internal Revenue Code.

Section 51(d)(13) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's federal tax return. Completion of this form is voluntary and may assist members of targeted groups in securing employment. Routine uses of this form include giving it to the state workforce agency (SWA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group. This form may also be given to the Internal Revenue Service for administration of the Internal Revenue laws, to the Department of Justice for civil and

criminal litigation, to the Department of Labor for oversight of the certifications performed by the SWA, and to cities, states, and the District of Columbia for use in administering their tax laws. 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 section 6103.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

- Recordkeeping** . . . 6 hr., 27 min.
- Learning about the law or the form** 24 min.
- Preparing and sending this form to the SWA** 31 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can send us comments from www.irs.gov/formspubs. Click on "More Information" and then on "Give us feedback." Or you can send your comments to:

Internal Revenue Service
Tax Forms and Publications
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send this form to this address. Instead, see *When and Where To File* in the separate instructions.



Work Opportunity Tax Credit
Individual Characteristics Form (ICF)

1. Control No. (For Agency use only)	SWA / AGENCY INFORMATION (See instructions on pg 4)	2. Date Received (For Agency Use only)
EMPLOYER INFORMATION		
3. Employer Name	4. Employer Mailing Address, Telephone No. and Email Address	5. Employer Identification Number (EIN)
JOB APPLICANT INFORMATION		
6. Applicant Name (Last, First, MI)	7. Social Security Number _____ - _____	8. Have you worked for this employer before? YES: <input type="checkbox"/> NO: <input type="checkbox"/>
JOB APPLICANT CHARACTERISTICS FOR WOTC TARGETED GROUP(S) CERTIFICATION		
9. Employment Start Date	10. Starting Wage	11. Job Position (Title) or SOC (Standard Occupation Classification)
<p>Directions: Read the following statements carefully and check any of following statements that apply to the job applicant. Provide additional information where requested and as needed for targeted group eligibility determination.</p>		
<p>12. Qualified IV-A Recipient Check here if the job applicant is a Qualified IV-A Recipient <input type="checkbox"/></p> <p>If the job applicant is a member of a family receiving Temporary Assistance for Needy Families (TANF), enter the name of the primary benefits recipient: _____, and the city and state(s) where benefits were received: _____</p>		
<p>13. Qualified Veteran Check here if the job applicant is a veteran of the U.S. Armed Forces <input type="checkbox"/></p> <p>If the job applicant (veteran) is a member of a family receiving Supplemental Nutrition Assistance Program (SNAP) benefits, enter the name of the primary benefits recipient: _____, and the city and state(s) where benefits were received: _____.</p> <p><i>Note: Additional information may be requested to determine the job applicant's qualified veteran eligibility, such as proof of being entitled to compensation for a service-connected disability or having aggregate periods of unemployment.</i></p>		
<p>14. Qualified Ex-Felon Check here if the job applicant is an Ex-Felon <input type="checkbox"/> Check if the job applicant is in a Work Release Program: <input type="checkbox"/></p> <p>Enter date of felony conviction (mm/dd/yyyy): _____ and release date: _____</p> <p>Federal conviction: <input type="checkbox"/> State conviction: <input type="checkbox"/> List applicable state: _____.</p>		

15. Designated Community Resident (DCR)

Check if the job applicant is at least age 18 but not age 40 on the hiring date, and resides in a Rural Renewal County (RRC) or an Empowerment Zone (EZ).

Enter *job applicant's birthday* (mm/dd/yyyy):

16. Vocational Rehabilitation Referral

Check here if the job applicant is a Vocational Rehabilitation (VR) Referral

Applicant was referred by (select one of the following): **Rehabilitation agency approved by the state;**

Employment Network under the Ticket to Work Program; Department of Veterans Affairs

17. Qualified Summer Youth Employee

Check here if the job applicant is a Qualified Summer Youth Employee

Enter the *job applicant's birthday* (mm/dd/yyyy): _____

18. Qualified Supplemental Nutrition Assistance Program (SNAP) Recipient

Check here if the job applicant is a Qualified SNAP (Food Stamps) Recipient

Enter *job applicant's birthday* (mm/dd/yyyy):

Enter the name of the *primary benefits recipient*: _____, and the *city and state(s)* where benefits were received: _____.

19. Qualified Supplemental Security Income (SSI) Recipient

Check here if the job applicant received or is receiving Supplemental Security Income (SSI)

20. Long-Term Family Assistance Recipient

Check here if the job applicant is a Long-term Family Assistance (long-term TANF) recipient

Enter name of the *primary benefits recipient*: _____, and the *city and state(s)* where benefits were received: _____.

21. Qualified Long-Term Unemployment Recipient

Check here if the job applicant is a qualified long-term unemployment recipient (LTUR)

Enter *city and state(s)* where UI claim records / UI wage records were filed: _____.

22. Sources used to document eligibility. List all supporting documentation submitted to SWA. Indicate next to each document listed whether it is attached (A) or forthcoming (F). **SWA Staff:** List all supporting documentation used in determining targeted group eligibility for the applicant. Enter your initials and date when the determination was made.

I certify that this information is true and correct to the best of my knowledge. I understand that the information above may be subject to verification.

23(a). Signature: (See instructions in Box 23.(b) for who signs this signature block)

23.(b) Indicate who signed this form:

- Employer, Employer's Preparer,
- SWA / Participating Agency,
- Job Applicant,
- Parent/Guardian (if job applicant is a minor)

24. Signature Date:

INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL CHARACTERISTICS FORM (ICF), ETA 9061. This form must be used together with IRS Form 8850 to help state workforce agencies (SWAs) determine eligibility for the Work Opportunity Tax Credit (WOTC). The form may be completed, on behalf of the job applicant, by: 1) the employer or employer's representative, 2) the applicant directly (if a minor, the parent or guardian must sign the form), or 3) a participating agency, and signed by the individual completing the form. This form is required to be used, without modification, by all employers (or their representatives) seeking WOTC certification. Eligibility requirements for each [targeted group is available on the IRS.gov website](#). Additionally, information on [how to submit certification requests, including WOTC Processing Forms](#).

Box 1 and 2. **State Workforce Agency (SWA) or Participating Agency.** For agency use only.

Box 3 - 5. **Employer Information.** Enter the name, address including ZIP code, telephone number, and employer identification number (EIN) of the employer requesting WOTC certification. Note: The EIN number must be a tax-identification number that is registered with the state (where the business is located), so the SWA can establish an employer-employee relationship where wages are paid (and federal taxes deducted). Do not enter information pertaining to the employer's representative, if any.

Box 6 - 11. **Applicant Information.** Enter the applicant's full name and social security number as they appear on the applicant's social security card. For job title (position), enter the job applicant's job title or the corresponding standard occupation classification (SOC). In Box 8, indicate whether the job applicant previously worked for the employer. This information will help the SWA to determine if the job applicant is a first-time, qualifying member of a WOTC targeted group(s). For additional information about non-qualifying rehires see 26 U.S.C. §51(i)(2).

Box 12 - 21. **Applicant Characteristics.** Read statements carefully, check any boxes that apply, and provide additional information where requested. Eligibility requirements for each [targeted group is available on the IRS.gov website](#).

Box 22. **Sources to Document Eligibility.** Employers and SWAs use this box to list the sources used to verify target group eligibility. Indicate in parentheses next to each document listed whether it is attached (A) or forthcoming (F). SWAs should follow this notation with their initials and the date the eligibility determination was completed. Some examples of acceptable documentation are provided below.

Examples of Documentary Evidence and Collateral Contacts. Employers: You may check with your SWA to find out what other sources you can use to verify targeted group eligibility. (You are encouraged to provide copies of documentation for each checked box).

QUESTIONS 12, 18 & 20

- TANF/SNAP (Food Stamp) Benefit History or Case Number Identifier
- Signed statement from Authorized Individual with a specific description of the months benefits that were received.

QUESTION 13

- DD-214 or Discharge Papers
- Reserve Unit Contacts
- Letter of Separation or other agency documents issued only by the Department of Veterans Affairs (DVA) on DVA Letterhead certifying the Veteran has a service-connected disability and signed by the individual who verified this information.
- UI Claims Records or UI Wage Records (for unemployed veteran sub-categories)

QUESTION 14

- Parole Officer's Name or Statement
- Correction Institution Records
- Court Records Extracts

QUESTIONS 15 & 17

- Birth Certificate or Copy of Hospital Record
- Driver's License
- School I.D. Card¹
- Work Permit¹
- Federal/State/Local Gov't I.D.
To determine if a Designated Community Resident lives in a Rural Renewal County, visit the US Postal Service website: www.usps.com. Click on Find Zip Code; Enter & Submit Address/Zip Code; Click on Mailing Industry Information; Download and Print the Information, then compare the county of the address to the list in the Instructions to IRS 8850 Form. For additional information, see the Instructions for the [IRS Form 8850 and the Empowerment Zone \(EZ\) Locator Tool](#), available on the dol.gov website.

QUESTION 16

- Vocational Rehabilitation Agency Contact

- Veterans Administration for Disabled Veterans
- Signed letter of separation or related document from authorized Individual on DVA letterhead or agency stamp with specific description of months benefits were received.

QUESTION 19

- SSI Record or Authorization / Evidence of SSI Benefits
- SSI Contact
- For SWAs: To determine eligibility for SSI and/or TTW Ticket Holders, send verification requests to the USDOL designated agency contact.

QUESTION 21

- Unemployment Insurance (UI) Wage Records
- UI Claims Records
- Self-Attestation Form, ETA Form 9175

BOX 22

- List all sources used and provided to the SWA to document targeted group eligibility. **SWA Staff:** List all documentation used to determine/verify eligibility in the targeted group(s) requested by the employer/representative, to reach the final determination.

Note:

1. Where a Federal/State/Local Gov't., School I.D. Card, or Work Permit does not contain age or birth date, another valid document must be obtained to verify an individual's age.
2. ESPL No. 05-98, dated 3/18/98, officially rescinded the authority to use Form I-9 as proof of age and residence. **Therefore, the I-9 is no longer a valid piece of documentary evidence.**

Box 23 (a). **Signature. The person who completes the form signs the signature block.**

Box 23 (b). **Signature Options.** (a) Employer or their Authorized Representative, (b) SWA staff, (c) Participating Agency staff, or (d) Applicant (If applicant is minor, the parent or guardian must sign).

Box 24. **Date.** Enter the month, day and year when the form was completed.

Note: An employer's authorized representative can be verified through an executed *Employer Representative Authorization Form* (ETA Form 9198). The representative is able to facilitate WOTC activities, which includes but is not limited to:

- Completing, signing and submitting WOTC processing forms;
- Requesting status application updates;
- Providing clarifying information, including supporting documentation;
- Receiving copies of notices and communications; and
- Submitting employer appeals.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB Control Number. Respondent's obligation to reply to these questions is required to obtain and retain benefits per law 104-188. Public reporting burden for this collection of information is estimated to average 20 minutes per response including the time for reading instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to the U.S. Department of Labor, Employment and Training Administration, Division of National Programs, Tools, and Technical Assistance, 200 Constitution Ave., NW, Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Project Control No. 1205-0371).

..... ✂
(Cut along dotted line and keep in your files)

TO: THE JOB APPLICANT OR EMPLOYEE,

Privacy Act Statement: *The Internal Revenue Code of 1986, Section 51, as amended and its enacting legislation, P.L. 104-188, specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification procedures of this program. The information you have provided completing this form will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary. However, the information is required for your employer to receive the federal tax credit. IF THE INFORMATION YOU PROVIDE IS ABOUT A MEMBER OF YOUR FAMILY, YOU SHOULD PROVIDE HIM/HER A COPY OF THIS NOTICE.*



Tuberculosis (TB) Test Notice

In accordance with The Home Care Services Consumer Protection Act, ALL Home Care Aides (HCA) are now mandated to have a copy of a TB test taken within the last two years, including the date of the most recent Tuberculosis examination, in their employee personnel files (Personnel Records).

For Home Care Aides submitting this information, the test must be taken within 30 days of receiving this notice. **Based on this requirement, completion of your TB test is an urgent matter to continue to provide respite care through the Regional Center.**

If you currently have your own medical insurance and/or doctor please feel free to set up an appointment through your own medical provider. If you do not have a medical provider, HGA has arranged for the following medical provider below to provide a TB test for you at the cost of **\$25.00 (cash only)**.

***Dr. Peace
4326 Western Ave.
Los Angeles, CA 90062
(323) 299-9914
Contact: Yancy***

If you would like to use our medical provider, you must contact their office directly to schedule an appointment. Appointments are available on Monday, Tuesday, and Wednesday afternoons. Once the exam is completed, please note that you will be required to return to the office 48 hours later to receive your results.

HGA has provided a form for your medical provider to use if requested. We will also accept TB test results from providers on their own letterhead with signature.

If you have any additional questions or concerns, please feel free to contact our office at the phone number provided below at your convenience.

Thank you,

Marc Adderly
Executive Director

*****If you have already provided HGA with TB Examination Documentation then please disregard this notice*****



Employee Tuberculosis (TB) Testing

Either the Two-Step TB Skin Test or an approved TB Screening Blood Test. If the second skin test or the single TB screening blood test is negative or if a documented history of negative TB screening test can be provided and the employee has no signs or symptoms of TB, a single "annual" TB Screening schedule can be maintained every year thereafter.

Name: _____ DOB: _____
(Please Print)

FIRST STEP of the TWO-STEP TST or ANNUAL SERIAL TB SKIN TEST (circle one)

Date Test Given: (mm/dd/yy); _____ Test Given By: _____

Site: Left Arm Measurement of Induration (millimeters): _____
 Right Arm

Date Test Read: _____ Test Read By: _____

Interpretation: Negative Positive

If a tuberculin skin test or the IGRA blood test is positive or a person exhibits signs and symptoms suspicious for tuberculosis, a medical evaluation is required.

If a person has previously documented positive TB screening test or a documented diagnosis of TB or LTBI in the past, perform an annual risk assessment instead of the TST or IGRA. Repeat CXR is only required in new symptoms develop.

CHEST X-RAY (CXR)

Documentation that the CXR was performed to rule-out tuberculosis due to a positive TB skin test, IGRA blood test or the development of signs or symptoms of TB must be in the CXR report or comments.

Date of CXR (mm/dd/yy): _____

Interpretation: Normal Abnormal

Comments:

For more information on TB Services and Testing: <http://publichealth.lacounty.gov/tb/TBTesting.htm>

Employee Tuberculosis Risk Assessment

Last Name: _____ First Name: _____ DOB: _____ Age: _____

1. Has the employee received BCG vaccination?

YES

NO

Notes Related to Assessment:

2. Date of last TST: _____ Results: _____

City & State: _____ Based on Induration and History the TST is:

Documented: NO YES Negative Positive

3. Has the employee had a chest x-ray in the past?

NO

YES Year: _____ Where: _____ Results: _____ Reason: _____

4. Has the employee lived or travelled outside of U.S.A within the last five (5) years?

NO YES (If Yes – Where/When) _____

5. Been in close contact with a person sick with TB?

NO YES (If Yes – Who/When) _____

6. Has the employee ever been treated for TB?

NO NOT SURE YES (ACTIVE TB) LTBI

Medications Taken: _____

Where: _____ Year: _____ Duration & Description of Tx: _____

7. Does the employee have any of the following symptoms? NO YES

Loss of Weight Usual Weight: _____ lbs. Today's Weight: _____ lbs.

Cough Fevers Night Sweats Fatigue Loss of Appetite Other: _____

Comments: _____

Note: If active TB is suspected do CXR

CXR Recommended NO YES Date: _____ CXR Result: _____

Medication Recommended? NO YES Date: _____ Medication Start Date: _____

Reason Refused Rx: Personal Preference Previous Treatment TB Education/Literature

I, attest that the above information is true, to the best of my knowledge and consent to an annual TB evaluation; I shall comply with NAC 441A.375 (7) which provides the following:

A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis.

Employee Signature: _____ Date: _____

Authorized Assessor's Signature: _____ Date: _____