AVHP ASTROCARE
ORIENTATION CHECKLIST

DESCIPTION

Authorization mail check form
Staffing Training
Direct Deposit Form
Employee Eligibility Verification
Employee information sheet
Form W-4
Attendant Services Guidelines
Attendant Services Provider Manual
HIPAA
Job Descriptions & Job Responsibilities
Orientation Policy
OSHA Training
Pay Schedule
Reference Check
Safety precautions
Worker Compensations Act form
Infection Control Manual

I, _____ have attended the ASTROCARE ORIENTATION and have verbally and visually reviewed and received the written information identified above.

Astrocare Staff

Employee Signature /date

ASTROCARE

EMPLOYEE INFORMATION

Name:_____ Date: _____

Address:_____ City_____ State_____ Zip Code_____

Phone:_____ Email:_____

Date of Birth: _____ Social Security No._____

Driver License No: _____ Sex: ☐Male ☐Female

Marital Status: ☐Single ☐Married ☐Divorce ☐Widowed

Emergency Contact: _____ Phone:_____

I have been informed and understand that I am not eligible to receive the following benefits:

- Retirement benefits
- Life Insurance
- Travel allowance
- Sick Leave
- Paid Vacation
- Holidays

_____ _____

Employee Signature Date

Office Use Only

Background Check Date: _____ Vesta EVV #: _____

Employee Start Date: _____ GP Emp #: _____

CPR Exp Date: _____ Medsys Emp #: _____

Pay Rate: _____ ☐HAB ☐LVN / RN / PCA

Pay Rate: _____ ☐MCO ☐RSP Direct Deposit: Yes☐ No☐

Voided Check/Bank Letter: Yes☐ No☐

Employee working for: _____

Work Schedule: _____

Accounting Signature and Date: _____

APPLICATION FOR EMPLOYMENT
SOLICITUD DE EMPLEO

EQUAL OPPORTUNITY EMPLOYER
IGUALDAD DE OPORTUNIDADES EN EL EMPLEO

PERSONAL INFORMATION / INFORMACIÓN PERSONAL

DATE / FECHA _____

NAME (LAST NAME FIRST) / NOMBRE (APPELLIDO PRIMERO)		SOCIAL SECURITY NO. / N E SEGURO SOCIAL	
PRESENT ADDRESS / DIRECCIÓN ACTUAL	CITY / CIUDAD	STATE / ESTADO	ZIP CODE / CÓDIGO POSTAL
PERMANENT ADDRESS / DIRECCIÓN PERMANENTE	CITY / CIUDAD	STATE / ESTADO	ZIP CODE / CÓDIGO POSTAL
PHONE NO. / TELÉFONO	REFERRED BY / RECOMENDADO POR		

EMPLOYMENT DESIRED / EMPLEO DESEADO

POSITION / PUESTO	DATE YOU CAN START FECHA QUE PUEDE EMPEZAR	SALARY DESIRED / SALARIO DESEADO
ARE YOU EMPLOYED NOW? ¿TRABAJA ACTUALMENTE? ☐ YES SÍ ☐ NO	ARE YOU LEGALLY AUTHORIZED TO WORK IN THE U.S.A.? ¿ESTÁ AUTORIZADO PARA TRABAJAR LEGALMENTE EN EE.UU.? ☐ YES SÍ ☐ NO	
EVER APPLIED TO THIS COMPANY BEFORE? ¿A POSTULADO A ESTA COMPA—ÍA ANTES? ☐ YES SÍ ☐ NO	WHERE? / ¿DÓNDE?	WHEN? / ¿CUÁNDO?

EDUCATION / EDUCACIÓN

NAME & LOCATION OF SCHOOL / NOMBRE Y LUGAR DE LA ESCUELA		YEARS ATTENDED A—OS QUE ASISTIÓ	DID YOU GRADUATE? SE GRADUÓ?	SUBJECTS STUDIED RAMOS ESTUDIADOS
HIGH SCHOOL ESCUELA SECUNDARIA				
COLLEGE UNIVERSIDAD				
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL ESCUELA DE OFICIOS, NEGOCIOS O POR CORRESPONDENCIA				

GENERAL INFORMATION / INFORMACIÓN GENERAL

SUBJECTS OF SPECIAL STUDY OR RESEARCH WORK / ESTUDIO ESPECIAL O TRABAJO DE INVESTIGACIÓN	
SPECIAL TRAINING / CAPACITACIÓN ESPECIAL	
SPECIAL SKILLS / APTITUDES ESPECIALES	
U.S. MILITARY SERVICE / SERVICIO MILITAR (EE.UU.)	RANK / RANGO

FORMER EMPLOYERS / EMPLEADORES ANTERIORES

BEGIN WITH MOST RECENT EMPLOYER / EMPIECE POR EL MÁS RECIENTE

DATE, MONTH AND YEAR FECHA, MES Y A—O	NAME & ADDRESS OF EMPLOYER NOMBRE Y DIRECCIÓN DEL EMPLEADOR	SALARY SALARIO	POSITION PUESTO	REASON FOR LEAVING RAZÓN DE SALIDA
FROM DESDE				
TO HASTA				
FROM DESDE				
TO HASTA				
FROM DESDE				
TO HASTA				
FROM DESDE				
TO HASTA				

CONTINUED ON OTHER SIDE
CONTINÚA EN EL REVERSO

REFERENCES / REFERENCIAS

GIVE BELOW THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.
DÉ EL NOMBRE DE TRES PERSONAS QUE NO SEAN SUS PARIENTES, Y A QUIENES CONOZCA AL MENOS UN AÑO

NAME / NOMBRE	PHONE / TELÉFONO	BUSINESS / PROFESIÓN	YEARS KNOWN / AÑOS QUE LO CONOCE

AUTHORIZATION / AUTORIZACIÓN

"I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal.

I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information.

I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.

This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the Americans with Disabilities Act (ADA) and other relevant federal and state laws."

"Certifico que los datos contenidos en esta solicitud son a mi mejor saber y entender verdaderos y completos, y entiendo que si me emplean, las declaraciones falsas contenidas en esta solicitud serán causal de despido.

Autorizo que se indaguen todos los datos, las referencias y los empleadores contenidos en esta solicitud, con el fin de recabar información relativa a mis empleos anteriores, y toda la información pertinente, personal o de cualquier otro tipo, que los mismos pudieran aportar, y libero a la compañía de cualquier responsabilidad por cualquier daño que pudiera resultar por la utilización de dicha información.

También entiendo y acepto que ningún representante de la compañía está facultado para hacer un contrato por algún periodo determinado, ni para hacer un contrato contrario a lo precedente, a menos que el mismo sea por escrito y firmado por un representante autorizado de la compañía.

Esta denegación no permite la divulgacion ni el uso de información médica o relacionada con discapacidades, tal como lo establece la ADA (Ley de Estadounidenses con Discapacidades) y otras leyes federales y estatales pertinentes."

DATE / FECHA _____ SIGNATURE / FIRMA _____

DO NOT WRITE BELOW THIS LINE
NO ESCRIBA DEBAJO DE ESTA LÍNEA

INTERVIEWED BY _____ DATE _____

REMARKS

HIRED	FOR DEPT.	POSITION	WILL REPORT	SALARY WAGES

APPROVED: 1. _____ 2. _____ 3. _____
EMPLOYMENT MANAGER — DEPARTMENT HEAD — GENERAL MANAGER

Astrocare - Reference Request

Date:_____ Check method of gathering reference data: ☐Verbal ☐Mail

Name of person giving reference:_____ Facility:_____

The individual named below is applying for a position as_____ and has given you as a reference. As we place great importance on the thorough screening of all our applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance_____
(Name of Company Representative)

Applicant Release

Applicant_____ _____
Last First MI Maiden

Position Held_____

Social Security #_____ Dates Employed: From_____ To_____

I hereby release from all liability the company or person completing this form, and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of the requesting company and other requesting third parties on a need to know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

_____ _____
Applicant Signature Date

1) Please confirm the applicant's employment. From_____ To_____
Date Date

2) Please comment on the applicant's attributes using the following scale:
4 = Excellent 3 = Good 2 = Fair 1 = Poor N/A = Not applicable

Quality of Work_____

Knowledge & Skills_____

Reliability & Attendance_____

Cooperation_____

Competence_____

Supervisory ability & capacity_____

Grooming_____

3) Please indicate specialty areas in which the applicant has had experience:_____

_____

4) Please indicate any special considerations necessary when giving assignments to this individual:

_____

5) Is applicant eligible for rehire? ☐Yes ☐No If no, why not?_____

_____

Please attach any additional comments.

_____ _____ _____
Signature Position/Title Date

HCL 11/00

Employment Eligibility Verification

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

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

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

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

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

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

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

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

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

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

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

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

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

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

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

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

Additional Information

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Acceptable Receipts

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

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

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

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

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

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

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

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

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

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

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

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

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

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

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

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

Address

City or town, state, and ZIP code

Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(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 . . . . . **1** $

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

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

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

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

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

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

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

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

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

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

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

Single or Married Filing Separately

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

Head of Household

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

ASTROCARE JOB DESCRIPTION

TITLE: AVHP PERSONAL CARE ATTENDANT CATEGORY I

REPORTS TO: PCA SUPERVISOR

JOB SUMMARY:

The Personal Care Attendant is an important member of the Astrocare health service team. Your function is primarily personal care service for the client and you can help the client regain self-confidence and independence. Your duties in performing client care include in the listed functions.

QUALIFICATIONS

1. High School graduate preferred, however, will accept eighth (8^{th}) grade education with appropriate experience
2. Preferable may have at least 6 months experience working with disabled individuals
3. Must have a valid CPR card
4. Must have a valid Texas ID or Texas driver's license
5. Must have automobile liability insurance
6. Must have a reliable automobile transportation
7. Must have legible handwriting and ability to maintain proper and accurate charting on participants and clients
8. Must be 18 years or older, not a spouse or parental guardian of the participant under 18 years of age that I will be assigned to
10. Demonstrate competency when competency cannot be determined through education and experience

PHYSICIAL DEMANDS

•Prolonged standing and walking • Ability to lift greater than 50 pounds •Good hand-eye coordination •Balancing •Ability to be mobile •Crouching •Kneeling/Crawling •Stooping •Twisting •Turning/Pivoting •Climbing •Reaching over head/extension •Grasping •Pushing/Pulling •Operation of equipment •Cooking.

ENVIROMENTAL

•Safety requirements – closed shoes, gloves •Exposure to fumes, humidity, cold, heat, dust, animals, body fluids •Operation of equipment – Automobile, Hoyer lift, microwave, scale, wheelchair, electric bed, computer, vacuum cleaner, washer/dryer.

PERSONAL PROTECTIVE EQUIPMENT (Provided by Astrocare)

•Gloves •Mouth Shields •Disposable gowns when applicable

ROUTINE FUNCTIONS

Perform and/or assist with personal care essential to the client's health needs as they relate directly to the client.

a. Ambulation activities
b. Mouth care, dentures care
c. Dressing and undressing activities
d. Bathing (bed bath, tub bath, shower)
e. Self-administered medications (remind client to take medication only)
f. Prepare, serve, feed, a well-balanced meal
g. Bathroom privileges (bedpan, commode, toilet)
h. Grooming (Shampoo, dry and comb hair shave, ordinary care of the nails)
i. Transferring (bed to chair, to wheelchair)
j. Tube feeding (HMA without RN Delegation)
k. Administration of enema (HMA without RN Delegation)
l. Change of ostomy appliances (HMA without RN Delegation)
m. Use of devices geared to disability (walker, wheelchair, hover lift, shower lift, etc.)
n. Change simple non-sterile dressings (HMA without RN Delegation)
o. Intermittent catheterization (HMA without RN Delegation)
p. RN Delegation
q. Promote self-care and independence
r. Notify Astrocare for any changes in clients' condition (environmental, hospitalizion, emergency)

Perform household tasks essential to the client's health needs as they relate directly to the client.

a. Opening mail
b. Wash client's laundry
c. List needed supplies
d. Wash dishes after meals
e. Light housekeeping
f. Make beds
g. Dust and vacuum client's room
h. Tidy kitchen, bathroom and client's room
i. RN Delegation
j. Documents services and tasks performed

Perform Escort or Transport tasks essential to the client's health needs as they relate directly to the client

a. Doctor's Visits
b. Grocery Shopping
c. Errands i.e. Library, Post Office, Banking etc.
d. Community Activities

ACKNOWELDGEMENT OF AVHP ATTENDANT JOB DESCRIPTION

I have read and understand my job description, its functions and requirements. I agree to practice within the scope of the job description, my knowledge, and training.

_____

Employee Name (Print)

_____ _____

Employee Signature Date

Employee Name_____

ATTENDANT EVALUATION ☐90 Day ☐Annual
STANDARDS OF PERFORMANCE

Personal Qualities		Work Ethics	
Courteous	_____	Document task actually performed	_____
Dependable	_____	Paperwork completed according to policy	_____
Respectful	_____	Paperwork neat and legible	_____
Cooperative	_____	Paperwork turned in on time	_____
Effective Communication	_____	Timesheets represent time worked	_____
Professional Appearance	_____	Accepts and show up for assignment	_____
Arrives for work on time	_____	Maintains Confidentiality	_____
		Call off in a timely manner	_____

Maintain client safety		**Maintain clean environment**	
Keep walkways clear of clutter	_____	Wash dishes after meals	_____
Perform safe transfer	_____	Vacuum/sweep/mop floors	_____
Keep side rails up	_____	Laundry as requested	_____
Keep floors dry	_____	Change bed linens	_____
Remove throw rugs	_____	Clean bathroom	_____
Utilize infection control	_____	Clean bedroom	_____
Inform of electrical hazards	_____	Tidy up environment	_____
Promote self care	_____		
Assist w/ambulation	_____		

Maintain clients' personal care needs		**Other Essential Functions**	
Bath when and as requested	_____	Notifies office for client changes	_____
Groom as requested	_____	Performs task according to ISP	_____
Dress as requested	_____	Follow RN Delegation when applicable	_____
Oral care as requested	_____	Follow clients' instructions	_____
Skin and nail care as requested	_____	Return calls to supervisor within 2 hours	_____
Skin care as requested	_____	Transport/Escort as requested	_____
Prepare meals as requested	_____	Number of complaints in 12 months	_____
Feed or assist as requested	_____	Number of absences in 12 months	_____
Assist w/medications as requested	_____	Number of "no shows" in 12 months	_____

EVALUATION CODE: 1=DOES NOT MEET EXPECTION 2=MEET EXPECTION 3= OCCASIONAL EXCEED EXPECTION 4=CONSISTANTLY EXCEEDS EXPECTION

Employee Comments: _____

_____

_____

Supervisor Comments: _____

_____

_____

Employee may appeal this evaluation to the next level supervisor. _____

_____
Employee Signature/Date

_____
Supervisor Signature/Date

ASTROCARE

AUTHORIZATION TO MAIL PAYROLL CHECKS

I, _____ request that my payroll check be mailed to my address on file. or alternate address listed below

_____

_____

_____

I understand Astrocare will not release payroll check until the Friday of pay week. I understand that once my payroll check is placed into the U.S. Postal System, Astrocare no longer has access or responsibility of the payroll check. I also understand and agree that if I do not receive my payroll check in the mail **within 10 business** days it is my responsibility to check with the Post Office. If my check is lost by the Postal Service, Astrocare has no responsibility to replace the check. Should I want a replacement check issued, I authorized Astrocare to withhold from the replacement check, the current bank charge to stop payment on the lost check.

_____ _____

Employee Printed Name Employee Signature

Date:_____

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION FORM

Use this form to setup direct deposit with Astrocare. This form must be completely filled out and have attached avoided check copy or letter from your bank on company letterhead displaying the routing number, account number, and signature of the authorized bank representative in order for the direct deposit to be entered into the payroll system. Please note the following:

1. *New direct deposits may take up to 3 pay periods to become active.* New direct deposits are placed into prenote status. This means that the information that you provided Astrocare must be verified by your bank before the direct deposit activates. Most banks respond quickly while others may take a while longer. Once a positive notification is received, your account will be moved to active status. Until then you will receive a paper check by mail to the address listed on your W4 unless arrangements are made prior to payroll for pickup.
2. If you are using this form to change your direct deposit to a different account, you will receive a paper check until the new account is in active status. Your checks will be mailed to the address that you provided on your W4 unless arrangements are made prior to payroll for pickup.
3. Astrocare will not be held liable for any non-sufficient funds fees (NSFs) that you may receive in your account. Please verify that funds are in your account BEFORE writing checks, having an automatic deduction take place, withdrawing money, or using your debit/check card. Astrocare will not reimburse these fees.
4. Direct deposits are scheduled to arrive at your bank on payday. Please speak with a bank representative before calling Astrocare to verify receipt of your direct deposit.
5. It is the employee's responsibility to make sure that Astrocare has the correct and updated information for your bank account. If the information is not correct and current, there may be a delay in receiving your funds. The delay could extend to the next pay period and a small fee may be assessed.
6. Astrocare will attempt to reverse funds that are deposited into your account in error. If the attempt is unsuccessful the employee is liable for all monies received in error and must either a.) repay the monies by money order or cashier's check only or b.) the monies will be treated as an advance and will be applied to future pay.

Account 1 Amount to Deposit- $_____ %_____

Financial Institution_____

Please Circle One ☐ Checking ☐ Savings

Routing (ABA) Number _____

Account Number _____

Account 2 Amount to Deposit- Remainder____ $_____ %_____

Financial Institution_____

Please Circle One ☐ Checking ☐ Savings

Routing (ABA) Number _____

Account Number _____

I hereby authorize Astrocare CLASS/CDS/AVHP, Inc. to initiate electronic debit and/or credit entries to the bank account(s) shown above for an allotted amount. I understand this will remain in effect until my written authorization is received by Astrocare CLASS, Inc. to terminate this authorization or until Astrocare CLASS, Inc. terminates this authorization.

Signature: _____

Printed Name: _____ Date: _____

Email Address: _____

A HEALTH CARE PROVIDER'S GUIDE TO THE HIPAA PRIVACY RULE:

Communicating with a Patient's Family, Friends, or Others Involved in the Patient's Care

U.S. Department of Health and Human Services • Office for Civil Rights

This guide explains when a health care provider is allowed to share a patient's health information with the patient's family members, friends, or others identified by the patient as involved in the patient's care under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. HIPAA is a Federal law that sets national standards for how health plans, health care clearinghouses, and most health care providers are to protect the privacy of a patient's health information.[1]

Even though HIPAA requires health care providers to protect patient privacy, providers are permitted, in most circumstances, to communicate with the patient's family, friends, or others involved in their care or payment for care. This guide is intended to clarify these HIPAA requirements so that health care providers do not unnecessarily withhold a patient's health information from these persons. This guide includes common questions and a table that summarizes the relevant requirements.[2]

COMMON QUESTIONS ABOUT HIPAA

1. **If the patient is present and has the capacity to make health care decisions, when does HIPAA allow a health care provider to discuss the patient's health information with the patient's family, friends, or others involved in the patient's care or payment for care?**

   If the patient is present and has the capacity to make health care decisions, a health care provider may discuss the patient's health information with a family member, friend, or other person if the patient agrees or, when given the opportunity, does not object. A health care provider also may share information with these persons if, using professional judgment, he or she decides that the patient does not object. In either case, the health care provider may share or discuss only the information that the person involved needs to know about the patient's care or payment for care.

   Here are some examples:

   - An emergency room doctor may discuss a patient's treatment in front of the patient's friend if the patient asks that her friend come into the treatment room.
   - A doctor's office may discuss a patient's bill with the patient's adult daughter who is with the patient at the patient's medical appointment and has questions about the charges.
   - A doctor may discuss the drugs a patient needs to take with the patient's health aide who has accompanied the patient to a medical appointment.
   - A doctor may give information about a patient's mobility limitations to the patient's sister who is driving the patient home from the hospital.

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[1] The HIPAA Privacy Rule applies to those health care providers that transmit any health information in electronic form in connection with certain standard transactions, such as health care claims. See the definitions of "covered entity," "health care provider," and "transaction" at 45 C.F.R. § 160.103.

[2] The full text of these requirements can be found at 45 C.F.R. § 164.510(b). Note that this guide does not apply to a health care provider's disclosure of psychotherapy notes, which generally requires a patient's written authorization. See 45 C.F.R. § 164.508(a)(2).

- A nurse may discuss a patient's health status with the patient's brother if she informs the patient she is going to do so and the patient does not object.

BUT:

- A nurse may not discuss a patient's condition with the patient's brother after the patient has stated she does not want her family to know about her condition.

2. If the patient is not present or is incapacitated, may a health care provider still share the patient's health information with family, friends, or others involved in the patient's care or payment for care?

Yes. If the patient is not present or is incapacitated, a health care provider may share the patient's information with family, friends, or others as long as the health care provider determines, based on professional judgment, that it is in the best interest of the patient. When someone other than a friend or family member is involved, the health care provider must be reasonably sure that the patient asked the person to be involved in his or her care or payment for care. The health care provider may discuss only the information that the person involved needs to know about the patient's care or payment.

Here are some examples:

- A surgeon who did emergency surgery on a patient may tell the patient's spouse about the patient's condition while the patient is unconscious.
- A pharmacist may give a prescription to a patient's friend who the patient has sent to pick up the prescription.
- A hospital may discuss a patient's bill with her adult son who calls the hospital with questions about charges to his mother's account.
- A health care provider may give information regarding a patient's drug dosage to the patient's health aide who calls the provider with questions about the particular prescription.

BUT:

- A nurse may not tell a patient's friend about a past medical problem that is unrelated to the patient's current condition.
- A health care provider is not required by HIPAA to share a patient's information when the patient is not present or is incapacitated, and can choose to wait until the patient has an opportunity to agree to the disclosure.

3. Does HIPAA require that a health care provider document a patient's decision to allow the provider to share his or her health information with a family member, friend, or other person involved in the patient's care or payment for care?

No. HIPAA does not require that a health care provider document the patient's agreement or lack of objection. However, a health care provider is free to obtain or document the patient's agreement, or lack of objection, in writing, if he or she prefers. For example, a provider may choose to document a patient's agreement to share information with a family member with a note in the patient's medical file.

4. May a health care provider discuss a patient's health information over the phone with the patient's family, friends, or others involved in the patient's care or payment for care?

Yes. Where a health care provider is allowed to share a patient's health information with a person, information may be shared face-to-face, over the phone, or in writing.

5. **If a patient's family member, friend, or other person involved in the patient's care or payment for care calls a health care provider to ask about the patient's condition, does HIPAA require the health care provider to obtain proof of who the person is before speaking with them?**

   No. If the caller states that he or she is a family member or friend of the patient, or is involved in the patient's care or payment for care, then HIPAA doesn't require proof of identity in this case. However, a health care provider may establish his or her own rules for verifying who is on the phone. In addition, when someone other than a friend or family member is involved, the health care provider must be reasonably sure that the patient asked the person to be involved in his or her care or payment for care.

6. **Can a patient have a family member, friend, or other person pick up a filled prescription, medical supplies, X-rays, or other similar forms of patient information, for the patient?**

   Yes. HIPAA allows health care providers to use professional judgment and experience to decide if it is in the patient's best interest to allow another person to pick up a prescription, medical supplies, X-rays, or other similar forms of information for the patient.

   For example, the fact that a relative or friend arrives at a pharmacy and asks to pick up a specific prescription for a patient effectively verifies that he or she is involved in the patient's care. HIPAA allows the pharmacist to give the filled prescription to the relative or friend. The patient does not need to provide the pharmacist with their names in advance.

7. **May a health care provider share a patient's health information with an interpreter to communicate with the patient or with the patient's family, friends, or others involved in the patient's care or payment for care?**

   Yes. HIPAA allows covered health care providers to share a patient's health information with an interpreter without the patient's written authorization under the following circumstances:

   - A health care provider may share information with an interpreter who works for the provider (e.g., a bilingual employee, a contract interpreter on staff, or a volunteer).

     For example, an emergency room doctor may share information about an incapacitated patient's condition with an interpreter on staff who relays the information to the patient's family.

   - A health care provider may share information with an interpreter who is acting on its behalf (but is not a member of the provider's workforce) if the health care provider has a written contract or other agreement with the interpreter that meets HIPAA's business associate contract requirements.

     For example, many providers are required under Title VI of the Civil Rights Act of 1964 to take reasonable steps to provide meaningful access to persons with limited English proficiency. These providers often have contracts with private companies, community-based organizations, or telephone interpreter service lines to provide language interpreter services. These arrangements must comply with the HIPAA business associate agreement requirements at 45 C.F.R. 164.504(e).

   - A health care provider may share information with an interpreter who is the patient's family member, friend, or other person identified by the patient as his or her interpreter, if the patient agrees, or does not object, or the health care provider determines, using his or her professional judgment, that the patient does not object.

For example, health care providers sometimes see patients who speak a certain language and the provider has no employee, volunteer, or contractor who can competently interpret that language. If the provider is aware of a telephone interpreter service that can help, the provider may have that interpreter tell the patient that the service is available. If the provider decides, based on professional judgment, that the patient has chosen to continue using the interpreter, the provider may talk to the patient using the interpreter.

8. **Where can I find additional information about HIPAA?**

The Office for Civil Rights, part of the Department of Health and Human Services, has more information about HIPAA on its Web site. Visit http://www.hhs.gov/ocr/hipaa for a wide range of helpful information, including the full text of the Privacy Rule, a HIPAA Privacy Rule Summary, fact sheets, over 200 Frequently Asked Questions, as well as many other resources to help health care providers and others understand the law.

HIPAA Privacy Rule Disclosures to a Patient's Family, Friends, or Others Involved in the Patient's Care or Payment for Care

	Family Member or Friend	Other Persons
Patient is present and has the capacity to make health care decisions	Provider may disclose relevant information if the provider does one of the following: (1) obtains the patient's agreement (2) gives the patient an opportunity to object and the patient does not object (3) decides from the circumstances, based on professional judgment, that the patient does not object Disclosure may be made in person, over the phone, or in writing.	Provider may disclose relevant information if the provider does one of the following: (1) obtains the patient's agreement (2) gives the patient the opportunity to object and the patient does not object (3) decides from the circumstances, based on professional judgment, that the patient does not object Disclosure may be made in person, over the phone, or in writing.
Patient is not present or is incapacitated	Provider may disclose relevant information if, based on professional judgment, the disclosure is in the patient's best interest. Disclosure may be made in person, over the phone, or in writing. Provider may use professional judgment and experience to decide if it is in the patient's best interest to allow someone to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information for the patient.	Provider may disclose relevant information if the provider is reasonably sure that the patient has involved the person in the patient's care and in his or her professional judgment, the provider believes the disclosure to be in the patient's best interest. Disclosure may be made in person, over the phone, or in writing. Provider may use professional judgment and experience to decide if it is in the patient's best interest to allow someone to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information for the patient.

ASTROCARE
SAFETY PRECAUTIONS

SAFETY: PERSONAL CARE

1. Wash hands before and after care.
2. Encourage client to assist as much as possible.
3. Have emergency phone numbers handy: police, fine department, ambulance, poison control, supervisor. Astrocare's 24-hour phone number is 281-931-5500
4. Use belt or sheet when assisting in and out of bed/chair.
5. Lock wheelchair brakes when assisting in and out.
6. Keeps side rails up
7. Use LOW setting only for hair dryer, heating pad.
8. Do NOT smoke if oxygen is present.
9. Do NOT put client in tub if client is unable to get in and out of tub alone, use tub bench, if possible, or hoyer lift for transfers.
10. DO NOT LIFT CLIENT without back support.
11. All incidents must be reported to Astrocare within the shift on which they occur (281) 931-5500.

SAFETY: MEAL PREPARATION

1. Wash hands before preparing meal.
2. Wash fruits and vegetables before serving.
3. Wash can tops before opening.
4. Defrost food in refrigerator.
5. Turn pot handles inward when cooling on stove top to prevent spills/burns.
6. Cover and refrigerate all leftovers promptly.
7. Do NOT leave knives or sharp objects on table on counter tops, handle, and knives carefully.

SAFETY: HOUSEHOLD

1. Keep floors dry
2. Check floors for cords, throw rugs and loose boards to prevent falls
3. Wear rubber gloves to clean oven
4. Do NOT mix cleaning products
5. Do NOT use electrical equipment with wet hands
6. Do NOT MOVE OR LIFT HEAVY FURNITURE OR OTHER OJECTS

_____ _____
Signature of Employee Date

_____ _____
Staff Signature Date

ASTROCARE
SAFETY PRECAUTIONS

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DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____ , acknowledge that a Computerized Criminal
APPLICANT or EMPLOYEE NAME (Please print)

History (CCH) check may be performed by accessing the Texas Department of Public Safety Secure Website and may be based on name and DOB identifiers. (This is not a consent form, but serves as information for the applicant.) Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411; Subchapter F.

Name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history record information (CHRI), therefore the organization conducting the criminal history check is not allowed to discuss with me any CHRI obtained using the name and DOB method. The agency may request that I also have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search.

In order to complete the fingerprint process I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online at www.txdps.state.tx.us */Crime Records/Review of Personal Criminal History* or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of $25.00 to the fingerprinting services company.

Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by this agency. Required for future DPS Audits)

_____
Signature of Applicant or Employee (optional)

_____
Date

_____
Agency Name (Please print)

_____
Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES ☐ NO ☐ _____ initial

Purpose of CCH: _____

Empl ___ Vol/Contractor ___ _____ initial

Date Printed:_____ _____ initial

Destroyed Date:_____ _____ initial

Retain in your files

Rev. 09/2015

EMPLOYMENT REQUIRMENTS

All unlicensed applicants seeking employment whose duties will involve any direct contact with individuals/client shall be notified prior to initiating the employment process that this Agency will initiate a **CRIMINAL HISTORY CHECK**, perform searches on **NURSE AIDE REGISTRY,** EMPLOYEE **MISCONDUCT REGISTRY, and TEXAS HHSC OIG AND US DEPARTMENT OF HHS OIG. Verification of employability of unlicensed applicants shall be obtained thru the Nurse Aide Registry and Employee Misconduct Registry at the DHS 1-800-452-3934**, to determine if the applicant is listed in either registry as having abused, neglected, or exploited a resident or consumer, or misappropriated a resident or consumer's property and is therefore unemployable. Any applicant listed in either registry as having such a finding of misconduct shall not be employed by this agency. All checks will be initiated at applicants' notification of the employment process.
The agency shall not employ or immediately discharge any employee involved in direct contact with individuals/client who is designated in the Nurse Aide Registry and/or Employee Misconduct Registry as having committed an act of abuse, neglect, exploitation or, misappropriation of a resident's or consumer's property.

Criminal History checks may be requested by the Agency on any employee during their course of employment after notification to the employee.

Search on the Nurse Aid and Misconduct Registries will be performed yearly.

TEXAS HHSC OIG AND US DEPARTMENT OF HHS OIG will be performed prior to hire and monthly on all employees.

All applicants will sign a **STATEMENT OF EMPLOYABILITY** (Addendum A) stating that they have not been convicted of any of the crimes under Convictions Barring Employment Offenses as outline in the Health and Safety Code Section 250.006, pursuant to SB 1245 and HB 1418, effective September 1, 2001. Applicants applying for employment whose duties will involve direct individuals/client contact shall sign a Verification of Employability Statement (Addendum A) stating that they have are not listed in the Nurse Aide Registry and/or Employee Misconduct Registry for reportable conduct as stated in Human Resources Code 48.002 and the Health and Safety Code, Section 253.

In an Emergency situation, a prospective employee may be hired prior to the receipt of the results of a Criminal History check, if the applicant is not listed as unemployable in the Nurse Aide Registry or Employee Misconduct Registry. Criminal History Check will be requested within 72 business hours of employment The Agency recognizes an **EMERGENCY SITUATION** as any time there is a potential for the number of employees falls below the desired staffing which may put the participant/individuals/client's health and safety at risk.

If notification is received by the Agency that an employee has been convicted of one of the Convictions Barring Employment Offenses, the employee will receive notification of DPS findings and will be immediately terminated.

If notification is received by the Agency that an employee has other than Convictions Barring Employment conviction, the Administrator/Designee, may place the employee on temporary leave of absence without pay. The employee must complete the appeal process (See Addendum C). If the person requests a review within twenty (20) days of receipt of the notice, the required documentation will be forwarded to the Administrator/Designee and scheduled for determination.
A notice of determination will be sent to the person after the review process is completed. Factors considered by the Administrator/Designee include:

- The misdemeanor or felony classification of the offense at the time it was committed
- The age of the person when the offense was committed
- Evidence of rehabilitation
- Employment history
- Mitigating circumstances at the time the offense was committed
- Such other matters as the person may wish to submit.

All matters should be submitted in document form and may include letters, affidavits, transcripts, letters of recommendation or character references, or employment records. Should the person fail to request an administrative review within twenty (20) days of the notice, the agency will proceed with termination proceedings.

Individuals may appeal directly to Department of Public Safety if the information on the criminal history is inaccurate. A certified fingerprint card and request for a corrected criminal history check must be provided to DPS.

The CRIMINAL HISTORY RECORD will include the signed STATEMENT OF EMPLOYABILITY and VERIFICATION OF EMPLOYABILITY which will be maintained in the personnel file.

All criminal records received by the agency are privileged information and are for the exclusive use of DPS and the agency for which the information was requested. The records may not be released or otherwise disclosed to any person or agency except on court order or with the written consent of the person being investigated. An employee or person commits a Class B misdemeanor in violation of Government Code 411.085 subsection (a), if they obtain criminal history record information in an unauthorized manner, uses the information for an unauthorized purpose, or discloses the information to a person who is not entitled to the information or provides a person with a copy of a criminal history record. An employee or person commits a felony of the second degree if the person obtains, uses, or discloses criminal history record information for remuneration or for the promise of remuneration or employs another person to obtain, use or disclose criminal history record information for remuneration or for the promise of

remuneration. All violators will be reported to the appropriate authority. Employees shall be terminated upon conviction of violations. All criminal history records are placed in the employee personal file. When criminal history information is obtained and the applicant is not employed, the records are destroyed.

ADDENDUM A STATEMENT OF EMPLOYABILITY

By execution of this document, I acknowledge that I have been informed by the Agency, that a criminal history check will be performed on my name. I have informed this agency of all names (i.e., maiden, aliases) that I have used in the past. I understand that my employment is temporary pending the results of the criminal history check.

I have not been convicted of the following crimes that Bar Employment:

- An offense under Section 19, Penal Code (criminal homicide).
- An offense under Section 20, Penal Code (kidnapping and unlawful restraint).
- An offense under Section 21.02 Penal Code (continuous sexual abuse of young children
- An offense under Section 21.11, Penal Code (indecency with a child).
- An offense under Section 21.08, Penal Code (indecent exposure)
- An offense under Section 21.12, Penal Code (improper relationship between educator and student)
- An offense under Section 21.15, Penal Code (improper photograph or visual recording)
- An offense under Section 22.05, Penal Code (deadly conduct)
- An offense under Section 22.011, Penal Code (sexual assault).
- An offense under Section 22.021, Penal Code (aggravated sexual assault)
- An offense under Section 22.02, Penal Code (aggravated assault).
- An offense under Section 22.04, Penal Code (injury to a child, elderly, disabled individuals).
- An offense under Section 22.041, Penal Code (abandoning or endangering child).
- An offense under Section 22.07, Penal Code (terroristic threat)
- An offense under Section 22.08, Penal Code (aiding suicide).
- An offense under Section 25.031, Penal Code (agreement to abduct from custody).
- An offense under Section 25.08, Penal Code (sale or purchase of a child).
- An offense under Section 28.02, Penal Code (arson).
- An offense under Section 29.02, Penal Code (robbery)
- An offense under Section 29.03, Penal Code (aggravated robbery).
- An offense under Section 33.021, Penal Code (online solicitation of a minor)
- An offense under Section 34.02, Penal Code (money laundering)
- An offense under Section 35A.02, Penal Code (Medicaid fraud)
- An offense under Section 42.09, Penal Code (cruelty to animals)
- An Offense under Section 42.092 Penal Code (cruelty to nonlivestock animal

- A conviction under the laws of another State, Federal Law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed under 30.02 Penal Code Subdivisions (1)-(13).
- **§15.01** — Criminal Attempt of any offense listed as a bar
- **§43.03** — Promotion of Prostitution
- **§43.04** — Aggravated Promotion of Prostitution
- **§43.05** — Compelling Prostitution
- **§43.25** — Sexual Performance by a Child
- **§43.26** — Possession or Promotion of Child Pornography
- A conviction under the laws of another State, Federal Law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed above.
- Any offense Astrocare determines to be contraindicated to employment

A person may not be employed in a position which involves direct contact with a consumer before the fifth anniversary of the conviction date of:

- An offense under Section 31, Penal Code (theft) punishable as a felony
- An offense under Section 30.02, Penal Code (burglary)
- An offense under Section 22.01 Penal Code (assault)
- An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution) that is punishable as a Class A misdemeanor or felony
- An offense under Section 32.16, Penal Code(securing execution of a document by deception) that is punishable as a Class A misdemeanor or felony
- An offense under Section 37.12, Penal Code (false identification as peace officer)
- An offense under Section 42.01(a)(7),(8) or (9), Penal Code (disorderly conduct)
- Any offense Astrocare determines to be contraindicated to employment

I am not listed in the **Nurse Aide Registry and/or the Employee Misconduct Registry** for reportable conduct as defined by Health and Safety Code, 48.002 for:

1. **Abuse**: The negligent or willful infliction of injury, unreasonable confinement, or intimidation, or cruel punishment with resulting physical or emotional harm or pain to an elderly or disabled person by the person's caretaker, family member, or other individual who has an ongoing relationship with the person. Sexual abuse of an elderly or disabled person, including any involuntary or nonconsensual sexual conduct that would constitute an offense under Section 21.08, Penal Code (indecent exposure) or Section 22, Penal Code (assault offenses), committed by the person's caretaker, family member, or other individual who has an ongoing relationship with the person.
2. **Exploitation:** The illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with the elderly or disabled person using the resources of an elderly or disabled person for monetary or personal benefit, profit, or gain without the informed consent of the elderly disabled persons.

3. **Neglect:** The failure to provide for one's self the good or services, including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide such goods or services.

EMPLOYEE ACKNOWLEDGEMENT

I hereby state that I have read and understand the list of offenses and employee misconduct as stated in Appendix A.

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment.

I understand that all information obtained by this agency regarding any criminal history will remain confidential and destroyed.

I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

I have been informed and understand that the agency will perform a search on the Nurse Aid and Misconduct Registries yearly.

I have been informed and understand that the agency will perform checks on the Texas HHSC OIG and the US Department of HHS OIG monthly for Medicaid Fraud and will report findings to the appropriate authorities.

_____

Printed Name

_____

Signature of Applicant/Date

Astrocare

PAYROLL AGREEMENT

- I _____ understand that all hours worked for the current pay period need to be reported every Monday before 9:00 AM CT.

- I understand that all unreported hours after 30 days are **NOT** eligible to be paid-out.

_____ _____

Employee Print Name Date

_____

Employee Signature

_____ _____

Astrocare Representative Date