CHINESE-AMERICAN PLANNING COUNCIL HOME ATTENDANT PROGRAM, INC.
CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

PERSONAL ASSISTANT TRACKING FORM

Name :_____ _____ **Date:** _____
Last 姓 *First* 名 日期

Social Security #:_____
工卡號碼:
Address:_____
Direction : **Number** 號碼 **Street** 街名 **Apt. #**
地址:

_____
City 城市 **State** 州 **Zip Code** 郵政號碼

Home Telephone #:_____ - _____ **Mobile #:**_____ - _____
電話 # 手機 #
Email Address:_____
電郵
Relationship with Consumer: _____
與客戶的關係
Emergency Contact Person & Telephone #_____
緊急聯絡人名字 /電話:
Mobile #:_____
手機 #:
Address:_____
地址:

Interview Date: _____ **Interviewer:** _____ **P.S. #**_____

Comments:_____

PA Profile Completed On:_____ **PA #**_____

☐ **Completed Receipt for Personnel Policies**
☐ **Completed W-4 From**

☐ **Physical Exam.** **Date:**_____

☐ **I.D. Card** **Date Issued:**_____

Date of Hire:_____

Date of Termination:_____

Chinese- American Planning Council Home Attendant Program, Inc.

Consumer Directed Personal Assistance Program

ACKNOWLEDGEMENT OF THE LIVE-IN RULES AND PROCEDURES

Home Care Employee Name:_____ Employee#_____

(Print)

My signature on this Form acknowledges that I have agreed to the Live-In Rules and Procedures as follows:

- A PA/HA/HHA assigned to a Consumer/Client designated as a "live-in" case will be paid no less than $19.15 per hour for all hours worked, excluding eight (8) hours of unpaid sleep time and three (3) hours of unpaid duty-free meal time or break periods.

- A "Live-in" case is a twenty-four (24) hour shift assignment with a Client/Consumer.

- A PA/HA/HHA working a Live-in case shall immediately report to his/her Case Coordinator/Personal Specialist at the completion of the Live-in case if the PA/HA/HHA was unable to receive five (5) hours uninterrupted sleep-time; unable to receive three (3) hours duty-free time for meal times or break periods; or interrupted by a call to duty at any time during his/her three (3) hours of meal times or break periods.

PA/HA/HHA Signature:_____

Date:_____

Personal specialist/ Coordinator Signature:_____

Date:_____

HireNYC Consent

The HireNYC program matches people who have received public assistance with jobs at organizations that have contracts with City agencies. The organizations participating in the program are required to prove that they have hired a certain number of people who have received public assistance.

If you sign below, you agree that, if you are hired, the Human Resources Administration (HRA) may tell this employer that you have received public assistance benefits.

This information will be used only to record your future employer's compliance with its hiring obligation under the Program. The employer is required to keep the information confidential, and not to let it affect the employer's hiring decision, your employment status, or conditions of your employment.

_____ _____

Applicant Signature Date

_____

Applicant Name (Please Print)

CHINESE-AMERICAN PLANNING COUNCIL
CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM
PHONE: (212) 219-8100 FAX: (212) 966-7371

NOTICE OF RECEIPT OF PERSONNEL POLICIES AND HIPAA PATIENT PRIVACY POLICIES

FOR

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

DATE: _____

I, (PRINT YOUR NAME) _____ (SS# _____)
AGREE TO THE PERSONNEL POLICIES AND TO THE HIPAA PATIENT PRIVACY POLICIES OF CDPAP, AND UNDERSTAND THAT THESE POLICIES ARE SUBJECT TO CHANGES. I UNDERSTAND THAT I WILL BE INFORMED IN THE EVENT OF ANY CHANGES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL INFORMATION CONTAINED IN THESE POLICIES AND THAT I MUST RETURN THIS FORM IN ORDER TO WORK FOR CPC HOME ATTENDANT PROGRAM, INC.

POLICY

UNDER NO CIRCUMSTANCE SHOULD I RELEASE PATIENT'S INFORMATION TO ANY THIRD PARTY THAT IS NOT INVOLVED WITH THE PATIENT'S CARE WITHOUT PATIENT'S AUTHORIZATION.

SIGNATURE X _____

CHINESE-AMERICAN PLANNING COUNCIL CONSUMER DIRECTED PERSOANL ASSISTANCE PROGRAM

PERSONAL ASSISTANCE ACKNOWLEDGEMENT FORM

I have received the Consumer Directed Personal Assistant Handbook, and understand that it is my responsibility to read and comply with the policies and rules outlined in the handbook.

Personal Assistance 's Signature
姓名

X _____

Date
日期

_____

CHINESE-AMERICAN PLANNING COUNCIL HOME ATTENDANT PROGRAM, INC.
CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM.

EMPLOYEE STATEMENT OF HIV CONFIDENTIALITY

I, the undersigned, understand the importance of observing strict HIV confidentiality policies. Therefore, I agree not to discuss/release any information obtained within the agency regarding any Chinese-American Planning Council Home Attendant Program, Inc. patient's HIV status, any patient's condition with any individual not directly associated with Chinese-American Planning Council Home Attendant Program, Inc. nor with Chinese-American Planning Council Home Attendant Program, Inc. employees who are not directly associated with the patient. I also agree that any information that is released regarding the patient's HIV status will only be done with proper authorization and/or in accordance with established agency policy for the release of the information.

My signature on this document indicates that I understand and agree to abide by the aforementioned policies, and that any breach in the aforementioned policies will result in implementation of the Disciplinary procedure up to and including possible IMMEDIATE DISMISSAL from employment at Chinese-American Planning Council Home Attendant Program, Inc.

Employee #: _____

Employee Name: _____ , _____
Last Name 姓 First Name 名

X _____ Date: _____
Employee's Signature 簽名 日期

_____ Date: _____
Supervisor's Signature

CPCHAP, INC.

CHINESE-AMERICAN PLANNING COUNCIL
CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM
One York Street, 2nd Floor, New York, NY 10013
PHONE: (212) 219-8100
FAX: (212) 966-7371

EMPLOYMENT AT CHINESE-AMERICAN PLANNING COUNCIL HOME ATTENDANT PROGRAM, INC. CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

APPLICANT Name (Print): _____

My signature below acknowledges that I am not an employee of Chinese-American Planning Council Home Attendant Program, Inc. until I have been notified that I have successfully satisfied all pre-employment hiring requirements set-forth by the New York State Department of Health (DOH). Additionally, on at least one occasion I must be assigned to provide service to a client/member/consumer within their home.

I have read this form and understand at what point I am an employee of Chinese-American Planning Council Home Attendant Program, Inc. I was also given an opportunity to ask any questions to clarify and gain a full understanding of when I am an employee of the Company .

Applicant Signature: X _____ Date: _____

Chinese-American Planning Council Home Attendant Program, Inc.
Consumer Directed Personal Assistance Program

Employee Compliance

Code of Safe Practices —General Office

It is our policy that everything possible will be done to protect employees from accidents. Safety is a cooperative undertaking requiring participation by every employee. Failure by any employee to comply with safety rules will be grounds for corrective discipline. Supervisors shall insist that employees observe all applicable Company, State and Federal safety rules and practices and take action as is necessary to obtain compliance.

To carry out this policy employees shall:

1. Report all unsafe conditions and equipment to your supervisor or safety coordinator.
2. Report all incidents, injuries and illnesses to your supervisor or safety coordinator immediately.
3. Means of egress shall be kept unblocked, well-lighted and unlocked during work hours.
4. In the event of fire, sound alarm and evacuate.
5. Upon hearing fire alarm, stop work and proceed to the nearest clear exit.
6. Gather at the designated location.
7. Only trained workers may attempt to respond to a fire or other emergency.
8. Exit doors must comply with fire safety regulations during business hours.
9. Stairways should be kept clear of items that can be tripped over and all areas under stairways that are egress routes should not be used to store combustibles.
10. Materials and equipment will not be stored against doors or exits, fire ladders or fire extinguisher stations. II. Aisles must be kept clear at all times.
12. Work areas should be maintained in a neat, orderly manner. Trash and refuse are to be thrown in proper waste containers.
13. All spills shall be wiped up promptly.
14. Files and supplies should be stored in such a manner as to preclude damage to the supplies or injury to personnel when they are moved. Heaviest items should be stored closest to the floor and lightweight items stored above.
15. All cords running into walk areas must be taped down or inserted through rubber protectors to preclude them from becoming tripping hazards.
16. Never stack material precariously on top of lockers, file cabinets or other high places.
17. Never leave desk or cabinet drawers open that present a tripping hazard. Use care when opening and closing drawers to avoid pinching fingers.
18. Do not open more than one upper drawer at a time, particularly the top two drawers on tall file cabinets.

19. Always use the proper lifting technique. Never attempt to lift or push an object which is too heavy. You must contact your supervisor when help is needed to move a heavy object.
20. When carrying material, caution should be exercised in watching for and avoiding obstructions, loose material, etc.
21. All electrical equipment should be plugged into appropriate wall receptacles or into an extension of only one cord of similar size and capacity. Three-pronged plugs should be used to ensure continuity of ground.
22. Individual heaters at work areas should be kept clear of combustible materials such as drapes or waste from wastebaskets. Newer heaters, which are equipped with tip over switches, should be used.
23. Appliances such as coffee pots and microwaves should be kept in working order and inspected for signs of wear, heat or fraying of cords.
24. Fans used in work areas should be guarded. Guards must not allow fingers to be inserted through the mesh. Newer fans are equipped with proper guards.
25. Equipment such as scissors, staplers, etc., should be used for their intended purposes only and should not be misused as hammers, pry bars, screwdrivers, etc.
26. Cleaning supplies should be stored away from edible items on kitchen shelves.
27. Cleaning solvents and flammable liquids should be stored in appropriate containers.
28. Solutions that may be poisonous or not intended for consumption should be kept in well-labeled containers.

Chinese-American Planning Council Home Attendant Program, Inc.
Consumer Directed Personal Assistance Program

ACKNOWLEDGEMENT OF RECEIPT AND REVIEW OF CODE OF SAFE PRACTICES

TO ALL EMPLOYEES: ATTACHED IS A COPY OF THE CODE OF SAFE PRACTICES. THESE GUIDELINES ARE PROVIDED FOR YOUR SAFETY.

IT IS THE RESPONSIBILITY OF THE OPERATIONS MANAGER TO PROVIDE AND REVIEW THIS CODE WITH EACH EMPLOYEE. IT IS THE EMPLOYEE'S RESPONSIBILITY TO READ AND COMPLY WITH THIS CODE.

ATTACHED COPY OF THE CODE OF SAFE PRACTICES ARE FOR YOU TO KEEP.

PLEASE SIGN AND DATE BELOW AND RETURN ONLY THIS PAGE TO:

I HAVE READ AND UNDERSTAND THE CODE OF SAFE PRACTICES.

_____

Name

_____

Signature

_____

Date

Notice and Acknowledgement of Pay Rate and Payday Under Section 195.1 of the New York State Labor Law for Home Care Aides Wage Parity and Other Jobs

[CDPAP Health Coverage]
effective Jan 1, 2024

1. Employer Information

Name:
Chinese-American Planning Council Home Attendant Program, Inc.
Doing Business As (DBA) Name(s):
N/A

FEIN (optional):

Physical Address:
1 York Street 2nd floor
New York, NY 10013
Mailing Address:
1 York Street 2nd floor
New York, NY 10013
Phone: 212-219-8100

2. Notice given:

☐ At hiring

☒ Before a change in pay rate(s), allowances claimed or payday

Note: Live-in employees must be paid at least 13 hours for each 24 hour period, provided they receive 8 hours of sleep, with five hours of uninterrupted sleep and 3 hours off for meals. If an employee does not receive 5 hours of uninterrupted sleep, the employee must be paid for all 8 hours. If the employee does not receive meal periods free from duty, the employee must be paid for all 3 hours designated for meals.

3. Employee's Rate(s) of Pay for Each Type of Work Shift:

$ 19.15 per hour for weekdays
$ 19.15 per hour for weekend
$ 19.15 per hour for mutual case

3a. Wage Parity Rates:

$ 19.15 per hour for regular wage
$ 0.68 per hour for additional wage
$ 1.26 per hour for supplemental wages*

4. Allowances:

☒ None
☐ Tips _____ per hour
☐ Meals _____ per meal
☐ Lodging _____
☐ Other _____

5. Regular Payday: Friday

6. Pay is:

☐ Weekly
☒ Bi-weekly
☐ Other: _____

7. Overtime Pay Rate(s) for each type of work or shift:

Single Pay Rate: $ 28.73 per hour
This must be at least 1½ times the worker's regular rate with few exceptions.

Wage Parity Pay Rate: $ 28.73 per hour
This must be at least 1½ times the worker's regular rate with few exceptions.

Multiple Pay Rates: $ 28.73 per hour This must be at least 1½ times the worker's Weighted average of the multiple rates of pay for the week, with few exceptions.

8. Employee Acknowledgement:
On this date, I have been notified of my pay rate, overtime rate (if eligible), allowances, supplements and designated payday. I told my employer what my primary language is.

Check one:

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

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

_____
Print Employee Name

_____
Employee Signature

_____
Date

Joyce Tan / Supervisory Bookkeeper
Preparer's Name and Title

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

Please note: It is unlawful for an employee with protected class status to be paid less than an employee without protected class status, if they are performing substantially equal work. Employers also may not prohibit employees from discussing wages with their co-workers.

*Attach Wage Parity supplement notification page 2.

LS 62 Notice to Wage Parity Home Care Aides - (cont'd)
Benefit Portion of Minimum Rate of Home Care Aide Total Compensation

	Hourly Rate	Type of Supplement	Name & Address of Provider	Agreement/ Plan Information
Supplement Number	*$ XXX*	*(Pension, Welfare, or Other)*	*Insert Name and Address of Company or Organization Providing Benefit*	*Identify plan or agreement that creates the benefit, e.g., Union Local No. 1 Collective Bargaining Agreement or Insurance Company X Benefit Plan*
Supplement Number 1	1.12	Health	EmblemHealth: 5 Water St New York, NY 10041	PPO Plan
Supplement Number 2	0.14	Pension	VOYA: One orange way Windsor, CT 06095	CPC-CDPAP Pension Plan
Supplement Number 3				

**If wage supplements are paid as a single payment owed to multiple Taft-Hartley multiemployer plans, list only the following: (1) the total paid for the supplement or benefit package; (2) the types of benefits included in the package, e.g., pension, health and welfare, or other; (3) the name and address of the entity to whom payment is sent; and (4) the relevant CBA or letter of assent as the agreement.*

List any additional benefits and attach listing to this document.

Copies of the above listed agreements or summaries may be obtained by:

_____

Employee Acknowledgement:

On this day I have been notified of my pay rate, overtime rate, allowances, supplements/benefits, and designated payday provided on this form (LS 62) attached and this addendum on the date given below.

My primary language is _____. I have been given this notice in my primary language ☐ Yes ☐ No.

Employee Name (Print): _____

Employee Signature: _____ Date Signed: _____

Preparer's Name and Title: Joyce Tan /Supervisory Bookkeeper

Notice and Acknowledgement of Pay Rate and Payday Under Section 195.1 of the New York State Labor Law for Home Care Aides Wage Parity and Other Jobs

[CDPAP No Health Coverage]
effective Jan 1, 2024

1. Employer Information

Name:
Chinese-American Planning Council Home Attendant Program, Inc.
Doing Business As (DBA) Name(s):
N/A

FEIN (optional):

Physical Address:
1 York Street 2nd floor
New York, NY 10013
Mailing Address:
1 York Street 2nd floor
New York, NY 10013
Phone: 212-219-8100

2. Notice given:

☐ At hiring

☒ Before a change in pay rate(s), allowances claimed or payday

Note: Live-in employees must be paid at least 13 hours for each 24 hour period, provided they receive 8 hours of sleep, with five hours of uninterrupted sleep and 3 hours off for meals. If an employee does not receive 5 hours of uninterrupted sleep, the employee must be paid for all 8 hours. If the employee does not receive meal periods free from duty, the employee must be paid for all 3 hours designated for meals.

3. Employee's Rate(s) of Pay for Each Type of Work Shift:

$ 19.15 per hour for weekdays
$ 19.15 per hour for weekend
$ 19.15 per hour for mutual case

3a. Wage Parity Rates:

$ 20.27 per hour for regular wage
$ 0.68 per hour for additional wage
$ 0.14 per hour for supplemental wages*

4. Allowances:

☒ None
☐ Tips _____ per hour
☐ Meals _____ per meal
☐ Lodging _____
☐ Other _____

5. Regular Payday: Friday

6. Pay is:

☐ Weekly
☒ Bi-weekly
☐ Other: _____

7. Overtime Pay Rate(s) for each type of work or shift:

Single Pay Rate: $ 28.73 per hour
This must be at least 1½ times the worker's regular rate with few exceptions.

Wage Parity Pay Rate: $30.41 per hour
This must be at least 1½ times the worker's regular rate with few exceptions.

Multiple Pay Rates: $28.73 per hour
This must be at least 1½ times the worker's Weighted average of the multiple rates of pay for the week, with few exceptions.

8. Employee Acknowledgement:
On this date, I have been notified of my pay rate, overtime rate (if eligible), allowances, supplements and designated payday. I told my employer what my primary language is.

Check one:

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

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

_____
Print Employee Name

_____
Employee Signature

_____
Date
Joyce Tan / Supervisory Bookkeeper
Preparer's Name and Title

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

Please note: It is unlawful for an employee with protected class status to be paid less than an employee without protected class status, if they are performing substantially equal work. Employers also may not prohibit employees from discussing wages with their co-workers.

*Attach Wage Parity supplement notification page 2.

LS 62 Notice to Wage Parity Home Care Aides - (cont'd)
Benefit Portion of Minimum Rate of Home Care Aide Total Compensation

	Hourly Rate	Type of Supplement	Name & Address of Provider	Agreement/ Plan Information
Supplement Number	*$ XXX*	*(Pension, Welfare, or Other)*	*Insert Name and Address of Company or Organization Providing Benefit*	*Identify plan or agreement that creates the benefit, e.g., Union Local No. 1 Collective Bargaining Agreement or Insurance Company X Benefit Plan*
Supplement Number 1	0.14	Pension	VOYA: One orange way Windsor, CT 06095	CPC-CDPAP Pension Plan
Supplement Number 2				
Supplement Number 3				

**If wage supplements are paid as a single payment owed to multiple Taft-Hartley multiemployer plans, list only the following: (1) the total paid for the supplement or benefit package; (2) the types of benefits included in the package, e.g., pension, health and welfare, or other; (3) the name and address of the entity to whom payment is sent; and (4) the relevant CBA or letter of assent as the agreement.*

List any additional benefits and attach listing to this document.

Copies of the above listed agreements or summaries may be obtained by:

_____

Employee Acknowledgement:

On this day I have been notified of my pay rate, overtime rate, allowances, supplements/benefits, and designated payday provided on this form (LS 62) attached and this addendum on the date given below.

My primary language is _____. I have been given this notice in my primary language ☐ Yes ☐ No.

Employee Name (Print): _____

Employee Signature: _____ Date Signed: _____

Preparer's Name and Title: Joyce Tan / Supervisory Bookkeeper

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

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

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

Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

2024

First name and middle initial	Last name	Your Social Security number
Permanent home address *(number and street or rural route)*	Apartment number	Single or Head of household ☐ Married ☐
		Married, but withhold at higher single rate ☐
City, village, or post office	State / ZIP code	**Note:** If married but legally separated, mark an ***X*** in the *Single or Head of household* box.

Are you a resident of New York City (this includes the Bronx, Brooklyn, Manhattan, Queens, and Staten Island)? ..... Yes ☐ No ☐

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

Before making any entries, see the *Note* below, and if applicable, complete the worksheet in the instructions.

1	Total number of allowances you are claiming for New York State and Yonkers, if applicable *(from line 19, if using worksheet)*	**1**
2	Total number of allowances for New York City *(from line 31, if using worksheet)*	**2**

Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.

3	New York State amount	**3**
4	New York City amount	**4**
5	Yonkers amount	**5**

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Penalty – A penalty of $500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee's signature	Date

Employee: Give this form to your employer and keep a copy for your records. Remember to review this form once a year and update it if needed.

Note: Single taxpayers with one job and zero dependents, enter ***1*** on lines 1 and 2 (if applicable). Married taxpayers with or without dependents, heads of household or taxpayers that expect to itemize deductions or claim tax credits, or both, complete the worksheet in the instructions. Visit *www.tax.ny.gov* (search: *IT-2104-I)* or scan the QR code below.

Employer: Keep this certificate with your records.

If any of the following apply, mark an ***X*** in each corresponding box, complete the additional information requested, and send an additional copy of this form to New York State. See ***Employer*** in the instructions. Visit *www.tax.ny.gov* (search: *IT-2104-I)* or scan the QR code below.

A Employee claimed more than 14 exemption allowances for New York State ..... A ☐

B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay *(mm-dd-yyyy) (see Box B instructions)*:

You may report new hire information online instead of mailing the form to New York State. Visit *www.nynewhire.com*.

Note: Employers **must** report individuals under an **independent contractor arrangement** with contracts in excess of $2,500 using the online reporting website above, **not** Form IT-2104.

Are dependent health insurance benefits available for this employee? ..... Yes ☐ No ☐

If *Yes*, enter the date the employee qualifies *(mm-dd-yyyy)*:

Employer's name and address *(Employer: complete this section only if you are sending a copy of this form to the New York State Tax Department.)*	Employer identification number

Scan here

https://www.tax.ny.gov/r/it2104i-2024

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

First Day of Employment (mm/dd/yyyy):

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS

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

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

Acceptable Receipts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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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.

CHINESE-AMERICAN PLANNING COUNCIL HOME ATTENDANT PROGRAM, INC.
CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM MCO/MLTC CONTRACTS
Telephone: 212-219-8100 Fax: 212-966-7371

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF PAYROLL

自動轉帳同意書

I hereby authorize my employer to deposit my net pay directly into my ( ) checking or ( ) savings account (select one) and to initiate (if necessary) debit entries and adjustments for any credit entries to my account.

To ensure that my account is properly credited, I have attached a voided check from my checking account, or a deposit slip from my savings account where my net pay will be deposited and completed the from below.

I agree that this authorization will remain in effect until I provide written notification to my employer terminating this service.

Signature (Firma 簽名) _____ Date (Fecha 日期) _____

Last Name (Apellido 姓) _____ First Name (Nombre 名) _____

Name as it appears on your account (Nombre como aparece en su cuenta 帳户上姓名) _____ Social Security Number (Numero de Seguro Social 工卡) _____

Name of your Bank (Nombre de banco 銀行名稱 _____ Address of your Bank _____

Routing Number (Numero de Banco 銀行号碼) _____ Account Number (Numero de Cuenta 帳戶号碼) _____

Attach VOID Check from your bank in the space below
(Adjunte el cheque ANULADO de su banco en el espacio *請貼上失效支票 / 儲蓄存款單)*

CHINESE-AMERICAN PLANNING COUNCIL HOME ATTENDANT PROGRAM, INC.
1 York Street, 2nd Floor, New York, NY 10013 Phone: (212) 219-8100 Fax: (212) 966-7371

HEPATITIS B VACCINE INFORMED CONSENT

TYPE B HEPATITIS: Type B hepatitis is an infection of the liver caused by the hepatitis B virus (HBV) usually transmitted by blood or blood products, or close personal contact.

HEPATITIS B AND EMPLOYEE HEALTH: Hepatitis caused by the hepatitis B virus (HBV) is an unpredictable disease with a variety of presentations and outcomes. It is estimated that 60-70% of people who are infected do not become ill. In this circumstance prior infection can only be detected by presence of antibody in blood. Acute symptomatic hepatitis B infection may result in serious liver injury which may incapacitate a person for weeks to months with approximately 5-10% of persons with type B hepatitis becoming carriers of the virus. Death occurs in 1-2% of patients either as a result of acute liver failure or complications. HBV also appears to be a causative factor in the development of cirrhosis and liver cancer. There is no specific treatment or cure for hepatitis B infection or disease.

HEPATITIS B VACCINE: Hepatitis B vaccine is a non-infectious vaccine that affords good protection against all forms of HBV infection. (This vaccine will not prevent hepatitis caused by other agents, such as hepatitis A, non A - non B hepatitis viruses, or other viruses known to affect the liver.). There is no evidence that the vaccine itself will cause type B hepatitis. Full immunization requires three doses of vaccine given over a six month period. The duration of immunity is long-term. However, some persons do not respond to 3 doses.

WHO SHOULD CONSIDER THE VACCINE: Hepatitis B vaccine is indicted for susceptible individuals at risk for contracting hepatitis B infection who have not previously had clinical hepatitis B infection or have no detectable serum antibody to the agent. This includes infants born to mothers who have a positive test for hepatitis B virus and for antigen exposure to the hepatitis B virus.

ANTIBODY TESTING: Susceptible individuals at risk for contracting hepatitis B infection may request antibody testing prior to deciding whether or not to receive HBV vaccination.

WHO SHOULD PROBABLY NOT TAKE THE VACCINE: The hepatitis B vaccine is contraindicated for pregnant or nursing mothers, and for individuals with severely compromised cardiopulmonary status (because of risk of immediate hypersensitivity reaction).

POSSIBLE VACCINE SIDE EFFECTS: The observed incidence of side-effects is very low. No serious side effects have been reported with the vaccine. A few persons experience tenderness and redness at the site of injection. Nausea, rash, and joint pain have been reported. A low-grade fever may also occur. The possibility exists that more serious side-effects may be identified with more extensive use.

IF YOU HAVE ANY QUESTIONS ABOUT HEPATITIS B OR THE HEPATITIS B VACCINE, PLEASE ASK.

願意 ACCEPTANCE STATEMENT/ACCEPTO LA VACUNA

I, _____, have read the above statement about hepatitis B and the hepatitis B vaccine. I have had an opportunity to ask questions and understand the benefits and risks of hepatitis B immunization as they are presently known. I understand that it is recommended that I receive three doses of vaccine over a six-month period. However, as with all medical treatment, there is no guarantee that I will become immune to HBV infection or that I will not experience an adverse side-effect from the vaccine. I request that this vaccine/antibody testing be given to me.

Signature of Person Receiving Vaccine/Testing _____

Address _____ Date_____

Date_____ Signature of Witness_____

	Date Vaccinated	Lot #
1.	_____	_____
2.	_____	_____
3.	_____	_____

不願意 REFUSAL STATEMENT/RECHEZO LA VACUNA

姓名 (Apellido, Nombre)

I, _____, have read the above information and realize that I am potentially at increase risk of exposure or development of hepatitis B infection. I choose not to receive the hepatitis B vaccine at this time. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

(Fecha:) 日期 Date/Time _____ (Firma :) Signature _____

簽名 Date/Time _____ Signature of Witness _____

CHINESE-AMERICAN PLANNING COUNCIL HOME ATTENDANT PROGRAM, INC.
CONSUMER DIRECTED PERSOANL ASSISTANCE PROGRAM
ONE YORK STREET, 2ND FLOOR, NEW YORK, NY10013
PHONE: (212)-219-8100 FAX: (212)-966-7371

Annual Tuberculosis Screening Questionnaire for Positive PPD Skin Test

Name
Last_____First_____Middle_____

Address_____

Home phone:( )_____-_____Cell phone:( )_____-_____

1. Have you ever had a TB skin test?Yes____ No____ Don't know_____
   If yes, please give date: _____. What was the result_____
   If positive, please provide documentation and proof of chest x-ray after skin test.
2. Have you ever been told that you have TB? Yes___ No___ If yes, when_____
3. Have you ever been treated for TB infection or disease? Yes_____ No_____
   If yes, when? _____. Which medicines did you take_____

4. Do you currently have any of the following symptoms?

Symptoms	Yes	No	Comments
Cough longer than 2 weeks			
Fever, chills, night sweats longer than 2 weeks			
Weakness			
Fatigue			
Lack of appetite			
Weight loss			
Chest pain			
Shortness of breath			
Blood streaked sputum			

5. Have you been exposed to anyone exhibiting any of the above signs and symptoms, or anyone who has had active tuberculosis? Yes____ No____

If yes, what type, if any, follow-up treatment did you receive?_____
_____
_____
_____

If I should notice any of the above-mentioned signs or symptoms, I understand that I am to immediately notify my physician and my employer.

HA. signature: X_____ Date:_____

MD/RN signature:_____ Date:_____

CHINESE-AMERICAN PLANNING COUNCIL HOME ATTENDANT PROGRAM, INC.
CONSUMER DIRECTED PERSOANL ASSISTANCE PROGRAM
ONE YORK STREET, 2ND FLOOR, NEW YORK, NY10013
PHONE: (212)-219-8100 FAX: (212)-966-7371

Cuestionario Annual de Tuberculosis Para Personas Positivas En La Prueba de Piel de PPD

Apellido:_____Nombre:_____Inicial_____

Direccion:_____

Telefono del hogar:( ) _____-_____ Celular:( )_____-_____

1. Ha tenido usted alguna vez una prueba de TB en la piel? Si____ No ____ No Se_____
   Si es si, de la fecha: _____. Cual fue el resultado? _____
   Si es positivo, provea documentacion y prueba de placas de pecho despues de la prueba.
2. Le han dicho alguna vez ha tenido infeccion de TB? Si ___ No____ Si es si, cuando? _____
3. Ha sido usted tratado/a por infeccion o enfermedad deTB? Si_____ No_____
   Si es si, cuando? _____. Cuales medicinas usted tomo? _____
4. Tiene usted actualmente algunos de estos sintomas?

Sintomas	Si	No	Comentarios
Tos por mas de dos semanas.			
Fiebre, escalofrios, sudor nocturno por mas de dos semanas.			
Debilidad			
Cansancio			
Falto de apetito			
Perdida de peso			
Dolor en el pecho			
Corto de respiracion			
Esputo con rayas sangrientas			

5. Ha sido usted expuesta/o a alguna persona que exhibe cualquiera de los sintomas o señales descritos arriba o con alguien que ha tenido tuberculosis activa? Yes____ No____

Si es si, que tipo de tratamiento, si alguno, usted recibio ?_____
_____
_____
_____

Si yo notara algunos de los sintomas o señales descritos arriba, entiendo que debo de notificar immediatamente a mi medico y mi patrono.

Firmal del paciente:_____ Fecha:_____

Firma del doctor/enfermera:_____ Fecha:_____

CHINESE-AMERICAN PLANNING COUNCIL HOME ATTENDANT PROGRAM, INC.

肺結核篩檢問卷(皮膚試驗陽性反應者須用)

姓_____名_____ 員工號碼:_____

地址：_____

住宅電話 :( )___-_____手提電話:( )____-_____

1. 你以前曾做過肺結核皮膚測試嗎 ？ 有___ 沒有___ 不知道___
   如果有，請填上測試日期：_____。 皮膚試驗結果_____
   如果是陽性反應，請提供文件証明及皮膚試驗後的 X 光照肺報告。
2. 你有否曾被告知患有肺結核病 有___ 沒有___ 如果有，是何時？_____
3. 你以前曾否接受過肺結核病或其他預防性的治療。 有___ 沒有___
   如果有，是何時？_____你服用何種葯物？_____
4. 你最近有沒有以下所述的症狀 ：

症狀	有	沒有	備註
咳嗽超過兩星期			
發燒發冷及晚上有盜汗超過兩星期			
體弱無力			
極度疲倦			
胃口欠佳			
體重減輕			
胸痛			
氣速			
咳痰有血			

5. 你曾否接觸過別人有以上症狀或被診斷患有肺結核病：有___ 沒有___
   如果有，是何種情況，及有沒有覆診及接受治療？_____

_____

_____

如果我知道有上述任何症狀，我明白一定要立刻通知醫生及我的僱主。

護理員簽名：_____ 日期:_____

醫生/護士簽名 ：_____ 日期：_____

CHINESE-AMERICAN PLANNING COUNCIL HOME ATTENDANT PROGRAM, INC.
(CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM)
1 York Street 2nd Floor New York, New York 10013
PHONE: (212) 219-8100 FAX: (212) 966-7371

VOLUNTARY REFUSAL OF INSURANCE FORM

I was given the opportunity to enroll in a group insurance plan offered by Chinese-American Planning Council, H.A.P. Inc., Consumer Directed Personal Assistance Program and I have voluntarily chosen **NOT to participate** in (to waive out of) the following individual plans offered me (as indicated by my initials on the selected lines below).

Please initial each line where coverage is being waived.

_____ **Refusal of BLUE CROSS BLUE SHIELD Vision Insurance**

_____ **Refusal of BLUE CROSS BLUE SHIELD Dental Insurance**

_____**Refusal of BLUE CROSS BLUE SHIELD Medical Insurance**

I acknowledge that I am **voluntarily** waiving out of (refusing) these benefits currently being offered to me. I also acknowledge that I have been advised that I may reconsider this decision at a later date, and participate (enroll) on the anniversary of the aforementioned coverages' renewal dates.

Please indicate **REASON FOR YOUR WAIVER OF COVERAGE** by placing an "XX" on the line of the reason for your waiver.

_____ **ENROLLED in MEDICAID Coverage (W1)**

_____ **ENROLLED in MEDICARE PARTS A, B and D Coverage (W2)**

_____ **ENROLLED Under SPOUSE'S/DOMESTIC PARTNER'S Medical Coverage (W3)**

_____ **ENROLLED Under PARENT(S) Coverage (Under Age 26) (W4)**

_____ **ENROLLED in VETERANS (VA) OR MILITARY RETIREE BENEFITS (W5)**

_____ **ENROLLED IN OTHER INSURANCE COVERAGE (W9) (please indicate)** ___

_____

_____ **OTHER REASONS (W10)** _____

PRINT NAME: _____ **SSN#:** _____–_____–_____

SIGNATURE: _____ **DATE:** _____/_____/_____

Updated 3-1-2023

CHINESE-AMERICAN PLANNING COUNCIL CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

CONTACTS

PA Name 姓名 :_____

CHINESE-AMERICAN PLANNING COUNCIL CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM, INC.

NOTIFICATION OF PERSONAL ASSISTANT PLACEMENT

Date 日期 :____/____/____

Personal Assistant # **Name of PA:**_____
Last 姓 *First* 名

_____ Social Security No 工卡號碼 :_____

Address:_____
地址

_____

Telephone #:_____ **Mobile #**_____
電話 手機

Consumer #:

_____

Address:_____

_____

Telephone #:_____ **Mobile #**_____

Starting Date:_____ **Termination Date:**_____

Reason for Termination:_____

Schedule Starting Date

	From	*To*
Sat		
Sun		
Mon		
Tue		
Wed		
Thur		
Fri		

☐ Duty Free

New Schedule Date

	From	*To*
Sat		
Sun		
Mon		
Tue		
Wed		
Thur		
Fri		

☐ Duty Free

New Schedule Date

	From	*To*
Sat		
Sun		
Mon		
Tue		
Wed		
Thur		
Fri		

☐ Duty Free

Personnel Specialist: _____

CHINESE-AMERICAN PLANNING COUNCIL CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

PERSONAL ASSISTANT LEAVE RECORD

PA Name:_____ SS #:_____
姓名 工卡號碼

Date		Vacation	Sick Leave	Leave of Absence	Pay Date Hrs. Paid
From	To				

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes: If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact

Chinese-American Planning Council Home Attendant Program, Inc. (CDPAP)

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Chinese-American Planning Council Home Attendant Program, Inc.	13-3203211
5. Employer address	**6. Employer phone number**
1 York Street, 2nd Floor	212-219-8100

7. City	8. State	9. ZIP code
New York	New York	10013

10. Who can we contact about employee health coverage at this job?

Zhen Ming Li

11. Phone number (if different from above)	12. Email address
	zmli@cpchap.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ☒ Some employees. Eligible employees are: 80 hours paid during a month for 3 consecutive months and 30 days waiting period.

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:
  Employee and Spouse cost per pay period $110
  Employee and Children cost per pay period $100
  Employee; Spouse and Children cost per pay period $160

  ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

CHINESE-AMERICAN PLANNING COUNCIL
HOME ATTENDANT PROGRAM. INC.
Tel: 212-219-8100 Fax: 212-966-7371

NOTICE OF HOME CARE PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USE AND DISCLOSURE OF HEALTH INFORMATION

CPC Home Attendant Program, Inc. may use your health information, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, for purposes of providing you treatment, obtaining payment for your care and conducting health care operations. The Agency has established policies to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Provide Treatment. The Agency may use your health information to coordinate care within the Agency and with others involved in your care, such as your attending physician and other health care professionals who have agreed to assist the Agency in coordinating care. For example, physicians involved in your care will need information about your symptoms in order to prescribe appropriate medications. The Agency also may disclose your health care information to individuals outside of the Agency involved in your care including family members, pharmacists, suppliers of medical equipment or other health care professionals.

To Obtain Payment. The Agency may include your health information in invoices to collect payment from third parties for the care you receive from the Agency. For example, the Agency may be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or the Agency. The Agency also may need to obtain prior approval from your insurer and may need to explain to the insurer your need for home care and the services that will be provided to you.

To Conduct Health Care Operations. The Agency may use and disclose health information for its own operations in order to facilitate the function of the Agency and as necessary to provide quality care to all of the Agency 's patients. Health care

operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Protocol development, case management and care coordination.
- Contacting health care providers and patients with information about treatment alternatives and other related functions that do not include treatment.
- Professional review and performance evaluation.
- Training programs including those in which students, trainees or practitioners in health care learn under supervision.
- Training of non-health care professionals.
- Accreditation, certification, licensing or credentialing activities.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Agency.
- Fundraising for the benefit of the Agency.

For example the Agency may use your health information to evaluate its staff performance, combine your health information with other Agency patients in evaluating how to more effectively serve all Agency patients, disclose your health information to Agency staff and contracted personnel for training purposes, use your health information to contact you as a reminder regarding a visit to you, or contact you as part of general fundraising and community information mailings (unless you tell us you do not want to be contacted).

<u>For Fundraising Activities</u>. The Agency may use information about you including your name, address, phone number and the dates you received care in order to contact you to raise money for the Agency. The Agency may also release this

information to a related Agency foundation. If you do not want the Agency to contact you, notify *CPC Home Attendant Program at 212.219.8100* and indicate that you do not wish to be contacted.

For Appointment Reminders. The Agency may use and disclose your health information to contact you as a reminder that you have an appointment for a home visit.

For Treatment Alternatives. The Agency may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY ALSO BE USED AND DISCLOSED.

When Legally Required. The Agency will disclose your health information when it is required to do so by any Federal, State or local law.

When There Are Risks to Public Health. The Agency may disclose your health information for public activities and purposes in order to:

- Prevent or control disease, injury or disability, report disease, injury, vital events such as birth or death and the conduct of public health surveillance, investigations and interventions.

- Report adverse events, product defects, to track products or enable product recalls, repairs and replacements and to conduct post-marketing surveillance and compliance with requirements of the Food and Drug Administration.

- Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.

- Notify an employer about an individual who is a member of the workforce as legally required.

To Report Abuse, Neglect Or Domestic Violence. The Agency is allowed to notify government authorities if the Agency believes a patient is the victim of abuse, neglect or domestic violence. The Agency will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

To Conduct Health Oversight Activities. The Agency may disclose your health information to a health oversight agency for activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action.

The Agency, however, may not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

In Connection With Judicial And Administrative Proceedings. The Agency may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Agency makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by State law, the Agency may disclose your health information to a law enforcement official for certain law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries pursuant to the court order, warrant, subpoena or summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the Agency has a suspicion that your death was the result of criminal conduct including criminal conduct at the Agency.
- In an emergency in order to report a crime.

To Coroners And Medical Examiners. The Agency may disclose your health information to coroners and medical examiners for purposes of determining your cause of death or for other duties, as authorized by law.

To Funeral Directors. The Agency may disclose your health information to funeral directors consistent with applicable law and if necessary, to carry out their duties with respect to your funeral arrangements. If necessary to carry out their duties, the Agency may disclose your health information prior to and in reasonable anticipation of your death.

For Organ, Eye Or Tissue Donation. The Agency may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue for the purpose of facilitating the donation and transplantation.

NOTICE OF HOME CARE PRIVACY PRACTICES

For Research Purposes. The Agency may, under very select circumstances, use your health information for research. Before the Agency discloses any of your health information for such research purposes, the project will be subject to an extensive approval process.

In the Event of A Serious Threat To Health Or Safety. The Agency may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Agency, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, the Federal regulations authorize the Agency to use or disclose your health information to facilitate specified government functions relating to military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

For Worker's Compensation. The Agency may release your health information for worker's compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than is stated above, the Agency will not disclose your health information other than with your written authorization. If you or your representative authorizes the Agency to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Agency maintains:

- **Right to request restrictions**. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Agency 's disclosure of your health information to someone who is involved in your care or the payment of your care. However, the Agency is not required to agree to your request. If you wish to make a request for restrictions, please contact **CPC Home Attendant Program at 212.219.8100.**

- **Right to receive confidential communications**. You have the right to request that the Agency communicate with you in a certain way. For example, you may ask that the Agency only conduct communications pertaining to your health information with you privately with no other family

members present. If you wish to receive confidential communications, please contact **CPC Home Attendant Program at 212.219.8100.** The Agency will not request that you provide any reasons for your request and will attempt to honor your reasonable requests for confidential communications.

- **Right to inspect and copy your health information**. You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to **CPC Home Attendant Program, Inc**. If you request a copy of your health information, the Agency may charge a reasonable fee for copying and assembling costs associated with your request.

- **Right to amend health care information**. You or your representative have the right to request that the Agency amend your records, if you believe that your health information is incorrect or incomplete. That request may be made as long as the information is maintained by the Agency. A request for an amendment of records must be made in writing to **CPC Home Attendant Program, Inc**. The Agency may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied if your health information records were not created by the Agency, if the records you are requesting are not part of the Agency's records, if the health information you wish to amend is not part of the health information you or your representative are permitted to inspect and copy, or if, in the opinion of the Agency, the records containing your health information are accurate and complete.

- **Right to an accounting**. You or your representative have the right to request an accounting of disclosures of your health information made by the Agency for certain reasons, including reasons related to public purposes authorized by law and certain research. The request for an accounting must be made in writing to **CPC Home Attendant Program, Inc**. The request should specify the time period for the accounting starting on or after April 14, 2003. Accounting requests may not be made for periods of time in excess of six (6) years. The Agency would provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

- **Right to a paper copy of this notice**. You or your representative have a right to a separate paper copy of this Notice at any time even if you or your representative have received this Notice previously. To obtain a separate

paper copy, please contact ***CPC Home Attendant Program at 212-219-8100.***

DUTIES OF THE AGENCY

The Agency is required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of its duties and privacy practices. The Agency is required to abide by the terms of this Notice as may be amended from time to time. The Agency reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all health information that it maintains. If the Agency changes its Notice, the Agency will provide a copy of the revised Notice to you or your appointed representative. You or your personal representative have the right to express complaints to the Agency and to the Secretary of DHHS if you or your representative believe that your privacy rights have been violated. Any complaints to the Agency should be made in writing to **CPC Home Attendant Program, Inc.** The Agency encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The Agency has designated ***Karina Lee, RN, Director of Patient Services*** as its contact person for all issues regarding patient privacy and your rights under the Federal privacy standards. You may contact **CPC Home Attendant Program, Inc.,**

Telephone: 212-219-8100 Fax: 212-966-7371

EFFECTIVE DATE

This Notice is effective April 14, 2003.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT *Karina Lee* at 212-219-8100.

CHINESE-AMERICAN PLANNING COUNCIL
HOME ATTENDANT PROGRAM, INC.

1 York Street, 2nd Floor
New York, NY 10013
Phone: (212) 219-8100
Fax: (212) 966-7371

All Home Care Aides
Location : 001,003,727, 927
(Pay Rate Effective 01/01/2024)

	Weekday Rate	Weekend Rate
Traditional Case	$ 19.15	$ 19.15
Mutual Case	$ 19.15	$ 19.15

	Live - In	
Traditional Case	$ 248.95	$ 248.95
Mutual Case	$ 248.95	$ 248.95

** Overtime rate: $28.73 per hour

Paid Holidays:

1. New Year's Day
2. Martin Luther King Day
3. Independence Day
4. Labor Day
5. Thanksgiving Day
6. Christmas Day

Holidays: Employees will be paid additional 0.5 times for worked holiday.

If worked on obaserved-holiday, NO additional pay is applicable.

CHINESE-AMERICAN PLANNING COUNCIL HOME ATTENDANT PROGRAM, INC.
CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

PERSONAL ASSISTANT WAGES AND BENEFITS

A. Eligibility

To become a participant, Personal Assistant must have 80 or more "hours worked" per month for three (3) consecutive calendar months. Personal Assistant will then become a participant one calendar month later. As long as Personal Assistants are eligible, their spouses and dependent children are covered for many (but not all) of the benefits to which Personal Assistant is entitled.

Employee Contribution: $18 per pay period
Family and Dependents Premium:
General Health Insurance: Spouse: $110 per pay period
Child(ren): $100 per pay period
Spouse + Child(ren) $160 per pay period
Dental: Spouse: $4 per pay period
Child(ren): $4 per pay period
Spouse + children: $8 per pay period
Vision: Spouse: $3 per pay period
Child(ren): $3 per pay period
Spouse + child(ren): $5 ppp

B. Wages

1. Effective January 1, 2024 Personal Assistants (PAs) shall receive a base wage rate of pay of $19.15 per hour worked, including hours worked on weekends (Saturday and Sunday) for single and mutual consumers, regardless of the number of hours completed with the consumer, provided that additional State and Federal funding is approved to support the Wage Increase.
2. PAs assigned to consumers designated as "Live-In" cases shall be paid at least 13 hours for each 24-hour **period,** excluding eight (8) hours of unpaid uninterrupted sleep time and three (3) hours unpaid for mealtime or break periods. If a PA does not receive 8 hours of uninterrupted sleep, the PA must be paid for all 8 hours, If the PA does not receive meal periods free from duty, the PA must be paid for all 3 hours designated for meals.
3. Overtime Pay Rate: $28.73 per hour if working over 40 hours per week.
4. Seventh day worked – Those employees who had verified schedules for 7 consecutive days, which would make them eligible for overtime for all the hours worked on the 7th day, regardless of the total number of hours worked during the week.

C. Fringes

1. Pay Time Off

Effective January 1, 2024, PAs who have completed the 90 days probationary period from their initial date of employment shall accrue up to seventy (70) Personal Time Off Hours (PTO), per year. PTO will be accrued at a rate of one hour for every thirty (30) hours worked, excluding overtime hours worked to a maximum of seventy (70) hours per year. "Live-in" cases will accrue PTO based on a twelve (12) hour workday. PTO not used or carried over at the end of the calendar year will be automatically paid out. PTO cannot be forfeited for any reason.

2. Holidays

Effective January 1, 2024, eligible Personal Assistants who actually work on the following six (6) holidays shall be paid at the rate of one and a half (1.5) times their regular hourly rate of pay for all hours worked on the holiday. PAs who do not work on the Holiday do not receive holiday pay.

- New Year's Day
- Martin Luther King Day
- Independent Day
- Labor Day
- Thanksgiving Day
- Christmas Day

3. Jury Duty Personal Assistants are required to serve on jury duty shall receive pay for scheduled work time upon submission of written proof executed by the administrator of the court at the amount equal to their base pay less their pay for jury duty.

4. Bereavement **Personal Assistants may, upon request, receive a maximum of three** consecutive days off with pay in the event of death of an immediate family member upon submission of sufficient verification of death.

5. **Training** The Personal Assistant will receive 40 or 60-hour basic training or certification with pay.

6. Other Benefits If Personal Assistants meet the statutory requirements, you become insured under:

- Worker's Compensation
- New York State Disability
- New York State Unemployment Insurance
- Family & Medical Leave

7. Paid Family Leave

On 1/1/2018, Paid Family Leave launches in New York State. All CPCHAP eligible Employees will be entitled to the Paid Family Leave that is added to our existing disability insurance policy at the expense of CPCHAP.
Eligibility
For Full-time employees- employees with a regular work schedule of 20 or more hours per week- are eligible after 26 consecutive weeks of employment.
Part-time employees- employees with a regular work schedule of less than 20 hours per week- are eligible after working 175 days, which do not need to be consecutive.
All eligible employees shall be provided through a short-term disability carrier, Standard Life Insurance Security Health Plan
Provide up to 12 weeks of paid family leave to eligible employees who take time off from work to care for family members.

8. **COVID-19 Sick Leave**

COVID-19 sick leave pays up to 14 days, 80 hours to home care workers (HCW) who are directed to quarantine or isolate by their employer or their doctors.

D. Others

1. Medical Eligible Personal Assistants shall be provided Hospital, Medical/Surgical, Optical, Vision, Dental and Prescription Drugs through the Major Medical with Anthem Blue Cross Blue Shield, Term Life Insurance/AD&D with Aetna Life Insurance Co. The Benefit Fund coverage is also extended to an eligible employee's spouse and children. Co-pay: $25 per doctor office visit

a. **Hospital –** Full in-patient hospital care up to 365 days each year. This includes medical/surgical care, maternity care, neonatal care, kidney dialysis, physical therapy and physical medicine. Limited hospital cares for alcohol and/or drug detoxification and mental and nervous disorders. Outpatient hospital care includes emergency room treatment, outpatient surgery, pre-surgical tests, alcohol and drug rehabilitation, chemotherapy and kidney dialysis. Hospice care (up to 210 days) is also provided. Co-pay: $100 per Emergency Room Visit (waived if admitted as inpatient, $250 per inpatient admission, $0 for Outpatient Hospital Facility Services.)

b. Medical/surgical – (Comprehensive coverage by Emblem Health)
Inpatient Hospital Services/Skilled Nursing Facility: $250 co-pay per admission
Outpatient Hospital facility services (including Ambulatory surgery): $100 copay per service/event.
Preventative Adult Care (Physical exam, pap smear, mammogram, prostate cancer screening): Covered in full.
Well Childcare: Covered in full.
Mental Health: $250 co-pay per admission.
Home health care: 200 visits per year. Covered in full.

c. **Prescription Drugs –** prescription drug benefits for Personal Assistants and covered spouse /dependents. Co-pay: Tier 1- $15 Tier 2- $35, Tier 3- $75
$50 Individual Deductible $100 Family Deductible
Deductible must be met before copay applies**.**

d. Vision Care – Annual eye examination and provides a $240 allowance for frames and prescribed lenses once every two years. Co-pay: $10

e. **Dental Care –** Basic and preventative services, oral exam and X-rays once every six months, dental emergencies, major restorative work, oral surgery, crowns, bridge, dentures and periodontal once every sixty-month period per tooth. Co-payments from $ 0.00 to some.

f. Life Insurance – $10,000 Term life insurance coverage per employee.

2. Pension Eligibility requirements for allocation of CPCHAP contribution: Only Personal Assistants who complete at least 1000 hours of service and are in the employ of CDPAP as of the last day of the Plan Year will receive an allocation; 100% immediate vesting. Vested benefits will be paid to Plan participants in a single lump sum amount.

This Personal Assistant Wage and Benefit Policy is intended as a general guide for Personal Assistants and the Agency and is subject to change or modification at any time.

Revised 1/1/2024

CHINESE-AMERICAN PLANNING COUNCIL HOME ATTEDANT PROGRAM, INC.

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

Personal Assistant Record Checklist

Name of Personal Assistant:_____

Part I (Complete Before Hiring)	PS	AVS	ADFO/DPS Approval
Personal Assistant Tracking Form			
Relationship with Consumer			
PA's Agency ID Photocopy			
Start Date (Potential or Expected)			
Pre-Employment Medical Exam Date			
Medical Exam Cleared?			
Medical Exam Scanned?			
Hepatitis Consent/Decline			
Exclusion Check			
Employment Letter			
HIPPA			
W4			
Live-In Rules and Procedures Signed			
Pay Rate and Pay Date Form			
HIV Confidentiality			
Handbook Receipt			
Schedule Sheet			
Code of Safe Practice (New)			
I-9 Form Completed & Signed			
Photocopy of I-9			
Staff Name			
Staff Signature			
Date Reviewed			

Part II (Annual Internal Audit)	PS		
Contact Note Reviewed			
Schedule Sheet updated			
Annual Medical Exam			
Abnormal Medical Finding Follow Up			
Staff Initial			
Date Reviewed			

Note: All PA's signatures must be accompanied with a date.

Updated March 2024

CHINESE-AMERICAN PLANNING COUNCIL
HOME ATTENDANT PROGRAM, INC.
1 York Street, 2nd Floor, New York, NY 10013
PHONE: (212) 219-8100 FAX: (212) 966-7371

February 14, 2017

Dear Home Care Employees,

Please note the following regarding your payroll.

- Pay Day (Payroll) is every two weeks on Friday and it covers the worked days up to previous Friday. It means that there is ONE WEEK gap between Pay Day and the last worked days included in the Paycheck.
- No Clock-In or No Clock-Out = NO PAY (until the work performed is verified)
- No Timesheet = NO PAY (until timesheet is received and processed)
- Timesheets (correctly completed) received by 5pm Friday will be guaranteed to be processed in the next earliest payroll week. (provided that the following Monday is not holiday)
- In order to ensure TIMELY receipt of the pay every other Friday, please enroll in DIRECT DEPOSIT. The wage will be directly deposited to your bank account.
- The First paycheck is always a paper check even if you enrolled in Direct Deposit.
- Paper checks are not guaranteed to be delivered on Pay Day as it depends on U.S. Postal Service's mail delivery time.
- If you have any payroll related questions, please check your paystub before calling the agency and call during the regular office hours (9am - 5pm M-F)
- Any payroll related inquiries cannot be addressed during weekends or holiday outside the regular office hours.