COMPLETE CARE CONNECT, LLC

7658 Slate Ridge Blvd,
Reynoldsburg, OH 43068
Phone: (614) 230-0332
Fax: (614) 423-5573

General Hire Checklist

Personnel records are considered confidential and are securely stored in locked drawers within the HR file cabinet. All documents are maintained and kept up to date. The documents listed in the Checklist must be completed, signed, and placed in the employee's personnel file for the record to be considered complete and in compliance with Agency Policy.

- ☐ Reference Verification
- ☐ Abuse Policy/Report Resource
- ☐ Drug-free Workplace Program
- ☐ Notification of Incidents/Refusal of Services
- ☐ Confidentiality & Conflict of Interest
- ☐ Passport Ethical Standard ☐ Not Required
- ☐ HIPAA Agreement, Notice & Receipt Acknowledgement
- ☐ Clients/Patient Bill of Rights
- ☐ Code of Ethics
- ☐ Insurance Waiver
- ☐ Hepatitis B Vaccine Consent/Decline
- ☐ I-9 Forms
- ☐ W-4 Forms
- ☐ Performance Appraisal Evaluation (In 1 year of hire date)
- ☐ Employee Orientation Checklist
- ☐ Acknowledgment of Employee Orientation
- ☐ Job Offer Letter

Employee Name: _____ **Date:** _____

H/R Coordinator: _____ **Hire Date:** _____

COMPLETE CARE CONNECT, LLC

Application for Employment

PERSONAL INFORMATION

Name (last, first, middle) | Date

Current home / mailing address

Street Address | Unit | City | State | Zip

Date of Birth | Social Security Number | Telephone (Primary) | Telephone (Other)

Email Address

Do you have a High School Diploma or GED?

Yes ☐ No ☐

POSITION PREFERENCES (Check all that apply)

Hours You're Available To Work

Full Time ☐ Days ☐ Swing Shift ☐ Weekends ☐

Part Time ☐ Evenings ☐ Overnight / Graveyard ☐

Position Type

Regular / Permanent ☐

Temporary / Short-Term ☐

Position Applied For:

Are you authorized to work in the U.S. on an unrestricted basis? Yes ☐ No ☐

Have you ever been convicted of a felony? *(Convictions will not necessarily disqualify an applicant for employment.)* Yes ☐ No ☐

If yes, explain:

Have you been told the essential functions of the job or have you been viewed a copy of the job description listing the essential functions of the job? Yes ☐ No ☐

Are you willing to work overtime if needed? Yes ☐ No ☐

QUALIFICATIONS Please list any education, training, or certifications relevant to the position you're applying for.

Employer, school or other | City, state

Telephone (Primary) | Field of employment/studies | Date (from) | Date (to)

Employer, school or other | City, state

Telephone (Primary) | Field of employment/studies | Date (from) | Date (to)

SPECIAL SKILLS List any skills or experience that would help you succeed in this role.

Do you have the following?

CPR ☐ Yes ☐ No Last Certified

First Aid ☐ Yes ☐ No Last Certified

STNA ☐ Yes ☐ No Last Certified

Add any additional skills or experience below:

REFERENCES

List references (not related to you) with full name, address, phone, and relationship.

Full Name	Address	Telephone (Primary)	Relationship

WORK HISTORY

Start with your most recent job and work backward. Include both paid and unpaid positions.

Company Name | Job Title | Supervisor's Name | Phone Number

City | State | Zip | Start Date (M/D/Y) | End Date (M/D/Y)

Duties | Starting Salary | Ending Salary

Reason for Leaving

Company Name | Job Title | Supervisor's Name | Phone Number

City | State | Zip | Start Date (M/D/Y) | End Date (M/D/Y)

Duties | Starting Salary | Ending Salary

Reason for Leaving

Company Name | Job Title | Supervisor's Name | Phone Number

City | State | Zip | Start Date (M/D/Y) | End Date (M/D/Y)

Duties | Starting Salary | Ending Salary

Reason for Leaving

I attest that the above referenced information is true and accurate to the best of my knowledge. I further give the agency permission to call any of my cited previous employers or reference candidate for information regarding my character, employee history, or work ethics.

Employee Signature

Date

COMPLETE CARE CONNECT, LLC

Reference Form

Date:

Manager Phone:

Address:

Applicant Name: SSN # :

ASSESSMENT OF WORK ETHIC

Category	*Excellent*	*Good*	*Fair*	*Poor*
Quality of Work	☐	☐	☐	☐
Reliability	☐	☐	☐	☐
Ability to work with others	☐	☐	☐	☐
Eligible for Rehire	☐	☐	☐	☐

If you answered "no" to rehire eligibility or have any other pertinent information, positive or negative, regarding the applicant's ability, character, and/or integrity, your signature below authorizes you to share this information. Please describe:

I hereby authorize any person, company, or organization to provide Complete Care Connect LLC with information regarding my employment record.

In consideration of Complete Care Connect LLC reviewing my application for employment, I hereby release all liability arising from this inquiry into my employment record, the communication of the requested information, or any actions taken by Complete Care Connect LLC based on that information. I further release Complete Care Connect LLC from any and all claims or causes of action I may otherwise assert in relation to this inquiry, communication, or action.

Signature of Applicant: _____ Date:

Reference Check Completed by: _____ Date:

Telephone Inquire ☐ Spoke with: _____

Mailing ☐ Date Mailed: _____

COMPLETE CARE CONNECT, LLC

Abuse Policy

Patients of Complete Care Connect LLC are our most valuable resource; therefore, their health and safety are of utmost importance. Always treat patients with dignity and respect under all circumstances. Mistreatment, including verbal or physical abuse of any kind, will not be tolerated. Any employee found guilty of abusing a patient is subject to immediate termination. Local authorities will be notified, and criminal charges may be filed against any employee found guilty of abuse.

Employee Signature _____ Date: _____

Agency Representative _____ Date: _____

Abuse Report Resources

Contact information for state protective services agencies are:

For Adults:
Franklin County Office on Aging
280 East Broad Street, Room 300
Columbus, Ohio 43215-4527

Senior Options: **(614) 462-6200**
Adult Protective Services: **(614) 462-4348**
Administration: **(614) 462-5230** Fax: **(614) 462-5300**
Ohio Relay Service TDD: **(800) 750-0750**

For Children:
If you suspect a child is being abused or neglected, please call the Franklin County Children Services 24-Hour Child Abuse Hotline at **(614) 229-7000.**

COMPLETE CARE CONNECT, LLC

Drug-Free Workplace Program

In accordance with our company's Drug-Free Workplace (HR Policy) and Federal and State law, all employees as a condition of employment must:

• Abide by the terms of the Drug-Free Workplace program.
• Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such a conviction.

Within thirty (30) days of receiving notice of an employee's conviction, our company will impose remedial measures on the employee convicted of drug abuse violations in the workplace. Remedial action taken against the employee can be up to and including termination.

EMPLOYEE ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING

Employee Signature _____ Date:

To: RN, LPN, Home Health Aides
From: Administrator

Notification of Incidents/Refusal of Services

If your client is admitted to the hospital, taken to the emergency room, goes on vacation, had an accident, had a change of address or refuse services, you must notify Complete Care Connect LLC immediately. Failure to follow this policy by not notifying Complete Care Connect LLC. regarding any of the above stated incidents will lead to **DISCIPLINARY ACTION AND GROUNDS FOR TERMINATION.**

If you falsify and submit timesheets for services not rendered to the patient while the client is in the hospital, on vacation, in a nursing home or in a rehab facility, you will be subject to legal actions warranted by the State of Ohio Department of Health. Ohio Department of jobs and Family Services, Office of the Attorney General, and the Office of the Inspector General.

Employee Name _____

Employee Signature _____ Date:

COMPLETE CARE CONNECT, LLC

Confidentiality/Conflict of Interest Statement

I understand and agree to refrain from unauthorized disclosure or use of confidential information from Complete Care Connect LLC. This includes any Information concerning clients, another employee, or agency operations. I recognize that the unauthorized release of confidential information nay subject me to a civil action under provision of federal and/or state law and may result in the termination of employment.

I acknowledge, by means of this statement, that I am not involved in any transaction, investment, or other legal or personal relationship in which I would profit directly or indirectly as a result of my position as _____ with Complete Care Connect, LLC

I agree to disclose to the Office of Complete Care Connect LLC. any actual, apparent, or potential conflicts of interest that may arise in the future.

I agree to abide by the determination of such matters made by the Agency Management.

I agree to hold harmless and indemnify Complete Care Connect LLC for any damages or costs associated with the defense of any claim arising out of any conflict of interest created knowingly or unwittingly on my part.

Employee Signature _____ Date:

Witness Signature _____ Date:

COMPLETE CARE CONNECT, LLC

Passport Employee Code of Ethics

Ethical, Professional, Respectful, and Legal Service Standards as defined in OAC 173-39-02

ODA Provider certification: requirements for providers to become and to remain certified.

OAC 173-39-02(B)(8) – effective 4/1/25

The provider shall not engage in any unethical, unprofessional, disrespectful, or illegal behavior including the following:

(a) Consuming alcohol while providing services to the individual.

(b) Consuming medicine, drugs, or other chemical substances in a way that is illegal, unprescribed, or impairs the provider from providing services to the individual.

(c) Accepting, obtaining, or attempting to obtain money, or anything of value, including gifts or tips, from the individual or his or her household or family members.

(d) Engaging the individual in sexual conduct, or in conduct a reasonable person would interpret as sexual in nature, even if the conduct is consensual.

(e) Leaving the individual's home when scheduled to provide a service for a purpose not related to providing the service without notifying the agency supervisor, the individual's emergency contact person, any identified caregiver, or ODA's designee.

(f) Failing to cooperate with or treating ODA or its designee respectfully.

(g) Engaging in any activity while providing a service that may distract the provider from providing the service as authorized, including the following:

(i) Watching television, movies, videos, or playing games on computers, personal phones, or other electronic devices whether owned by the individual, provider, or the provider's staff.

(ii) Non-care-related socialization with a person other than the individual (e.g., a visit from a person who is not providing care to the individual; making or receiving a personal telephone call; or, sending or receiving a personal text message, email, or video).

(iii) Providing care to a person other than the individual.

(iv) Smoking tobacco or any other material in any type of smoking equipment, including cigarettes, electronic cigarettes, vaporizers, hookahs, cigars, or pipes.

(v) Sleeping.

(vi) Bringing a child, friend, relative, or anyone else, or a pet, to the individual's place of residence.

(vii) Discussing religion or politics with the individual and others.

(viii) Discussing personal issues with the individual or any other person.

(h) Engaging in behavior that causes, or may cause, physical, verbal, mental, or emotional distress or abuse to the individual including publishing photos of the individual on social media without the individual's written or electronic consent.

(i) Engaging in behavior a reasonable person would interpret as inappropriate involvement in the individual's personal relationships.

(j) Making decisions, or being designated to make decisions, for the individual in any capacity involving a declaration for mental health treatment, power of attorney, durable power of attorney, guardianship, or authorized representative, unless otherwise permitted under rule 5160-44-32 of the Administrative Code.

(k) Selling to, or purchasing from, the individual products or personal items, unless the provider is the individual's family member who does so only when not providing services.

(l) Consuming the individual's food or drink, or using the individual's personal property without his or her consent.

(m) Taking the individual to the provider's business site, unless the business site is an ADS center, RCF, or (if the provider is a participant-directed provider) the individual's home.

(n) Engaging in behavior constituting a conflict of interest, or taking advantage of, or manipulating services resulting in an unintended advantage for personal gain that has detrimental results to the individual, the individual's family or caregivers, or another provider.

Workers Signature _____ Date:

COMPLETE CARE CONNECT, LLC

HIPAA Confidentiality and Non-Disclosure Agreement

Our agency's information systems contain confidential records pertaining to our business operations, our clients, business associates, health care professionals, and employees. Because this information is vital to the operation of our agency in providing quality care and services to our patients, it must be protected. As such, in accordance with current HIPAA regulations and agency policies governing the access, use, and disclosure of protected health or agency information, you have the responsibility to protect such data.

As an employee of this agency, you may have access to protected information. The purpose of this agreement is to provide you with information to assist you in understanding your duty and obligations relative to confidential information. Your signature on this document indicates that the information contained herein has been explained to you, you received a copy of this document, and that you understand the rules set forth. YOU AGREE:

1. To respect the privacy and confidentiality of any information you may have access to through our computer system or network that you will access or use only that information necessary to perform your job.

2. To refrain from communicating information about a patient in a manner that would allow others to overhear information or to discuss client information with anyone not permitted access to such information in accordance with the facility's established policy or patient wishes.

3. To disclose confidential patient business, financial or employee information ONLY to those authorized to receive it.

4. To safeguard and not disclose your password or user ID code or any other authorization you may have that allows your access to protected information. You accept responsibility for all entries and actions recorded using your password and user ID.

5. Not to attempt to learn or use another employee's password and user ID code to log-on to our agency's computer system or network.

6. To immediately report to the HIPAA Compliance Officer and suspicions that your password and user ID code has been compromised.

7. Not to release or disclose the contents of patient or agency record or report except to fulfill your work assignment.

8. Not to remove or copy any protected information or reports from their storage location except to fulfill your work assignment.

HIPAA Confidentiality and Non-Disclosure Agreement

9. Not to sell, loan, alter, or destroy any protected information or reports except as properly authorized within the scope of your job assignment.

10. Not to leave your computer terminal or workstation unattended without logging off or using your system's screen saver function before leaving your work area or securing hardcopy information so that it may not be disclosed to unauthorized persons.

11. Not to access or request any protected information that is not necessary to perform your assigned job function.

12. Not to permit others to access our agency's computer system or network using your password or ID code.

13. To permit your access to our agency's information system to be monitored.

14. Not to download or make copies of any software or applications without proper authorization or license.

15. Not to access or download any pornography or other illegal materials or perform any illegal activity such as gambling while on the agency's computer system or network.

16. Not to use our agency's computer system or network to send/forward harassing, insulting, defamatory, obscene, offending or threatening messages.

17. To report any suspected or known unauthorized access, use or disclosure of protected information.

18. To abide by the HIPAA policies and procedures set forth by the agency as well as current regulations governing privacy issues.

19. To restrict personal use of the agency's computer system or network to meal or break periods and to follow the agency's established policies governing such personal use.

I further understand that the duties and obligations set forth in this document will continue after the termination, expiration, and cancellation of this agreement to include my termination or employment. I also understand my password and user ID code can be temporarily or permanently revoked if I fail to abide by the rules set forth.

Employee Name _____

Employee Signature _____ Date: _____

Witness Signature _____ Date: _____

A copy of this completed document must be provided to the employee and a copy must be filed in the employee's personnel record.

COMPLETE CARE CONNECT, LLC

Our Patients Will

• Receive appropriate care without discrimination in accordance with physician orders.

• Be informed of any financial benefits when referred to an organization.

• Be fully informed of one's responsibilities.

• Receive information about the scope of services that the organization will provide and specific limitations on those services.

• Be informed of patient rights regarding the collection and reporting of OASIS information.

• Be informed of patient rights under state law to formulate advanced directives

• The right to be informed that OASIS information will not be disclosed except for legitimate purposes allowed by the Privacy Act.

• Be informed that OASIS information be kept confidential.

• Be informed of OASIS data collection and reason why.

• Be informed of the right to refuse to answer a specific question m regard to OASIS data collection.

• Be informed of the right to see, review, and request change to their OASIS assessment.

• Be informed of patient rights under state law to formulate advanced care directives.

• Be informed of anticipated outcomes of care and of any barriers in outcome achievement.

Employee Signature _____ Date:

COMPLETE CARE CONNECT, LLC

The Patient Bill of Rights must include, But not be limited to the right to

- Be fully informed in advance about service/care to be provided, including the
- disciplines that furnish care and the frequency of visits as well as any modifications to the service/care plan.
- Receive information about the services covered under the Medicare home health or hospice benefits.
- Participate in the development and periodic revision of the plan of care.
- Refuse care or treatment after the consequences of refusing care or treatment are fully presented.
- Be informed, both orally and in writing, in advance of care being provided, of the charges, including payment for service/care expected from third parties and any charges for which the patient will be responsible.
- Have one's property and person treated with respect, consideration, and recognition of patient dignity and individuality.
- The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent.
- Be able to identify visiting staff members through proper identification.
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property.
- Voice grievances/complaints regarding treatment or care, lack of respect of property or recommend changes in policy, staff, or service/care without restraint, interference, coercion, discrimination, or reprisal.
- Have grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated.
- Choose a health care provider, including choosing an attending physician.
- Confidentiality and privacy of all information contained in the patient record and of Protected Health Information.
- Be advised on agency's policies and procedures regarding the disclosure of clinical records.

COMPLETE CARE CONNECT, LLC

Code of Ethics - For All Staff

(Compliance with Care Delivery Policies)

1. Introduce yourself as Miss, Ms., Mrs., or Mr. Address the adult members in the same manner.

2. When answering the telephone say, "This is the Jones' residence, Mrs. Smith, home care aide speaking".

3. Do not give clients or families your personal address or telephone number. If asked, say that this is not permitted.

4. You are not to discuss personal problems, religious or political matters with the family.

5. You must NEVER take the client or the client's family away from the home for such purposes as shopping or attending a clinic, without prior consent from your supervisor.

6. The employee is responsible for his/her own belongings on the job and should avoid carrying large sums of money.

7. You are not to accept money, clothing or any other gifts.

8. Removal of client property or belongings is unlawful.

9. You are not permitted to sell anything to a client or to solicit a sale.

10. You are not permitted to make a loan to the client or the client's family. Report any such requests to your supervisor.

11. Do not make personal telephone calls to or from the home.

12. Make no telephone calls or visits to a family after hours or duty. Your home phone number is NEVER to be given to one of the clients or client's family for whom you care.

13. You are never to accept keys to a client's home. If this creates a problem, contact your supervisor.

14. You may take your own lunch and beverages. If the client asks you to eat with them, decline politely.

15. You are not permitted to bring friends or relatives to the client's home.

16. You are not to consume alcoholic beverages or use medicine or drugs for any purpose other than medical while in the client's home or prior to delivery of services.

17. You are not to smoke in the client's home, with or without client's permission.

18. Do not use the client's car.

19. No changes in hours or duties are to be made by the employee. If the family or client requests a change, they must contact the office. If the employee believes a change would be better for the client, he/she must discuss this matter with the supervisor.

20. What to report to your supervisor—
important happenings or changes in family situations, such as:

- No one home or no one answers the door
- Any changes in address
- An incident in the home (YOU MUST COMPLETE AN INCIDENT REPORT FORM)
- Other members of the family are ill
- Admitted to hospital unexpectedly

21. Plan to leave home early so you can be on time. If you feel you may be late, call the office and give a valid reason for tardiness.

22. Confidentiality: The client or client's family should not be discussed with anyone outside the agency. It is especially important that you do not talk about your client or his/her family with neighbors, friends, or relatives. It may cause problems for the family if you talk about things you learn while with the client and client's family.

23. Inform your supervisor of any unusual behavior or conditions:

- Serious shortage of food or clothing
- Serious disagreement among family members
- Appearance of insects or pests
- Severe behavior toward another member of the family
- Lack of cooperation from the family
- Client or family pressure to do tasks other than what is written on the plan of care

24. If illness makes it impossible for you to work, telephone the office immediately. We need ample time to restaff the shift.

25. Be friendly, pleasant, interested in the client and his/her family, but DO NOT BE PERSONAL.

26. Do not give the client any medication or treatment which you have not already been instructed to do by the RN. Home health aides cannot administer any medications to the clients.

27. Call the supervisor when in doubt about what to do in any situation.

28. Do not give the client any medical advice, refer the client to their attending physician.

29. Any minor incidence that might occur must be reported immediately. Example: Patient fall without injury, skin tear, etc.

30. Learn how the family and client like things so that you can fix it their way, making sure you follow the instructions you have received.

31. When instruction you are given do not seem to be working out, talk it over with your supervisor.

32. If you have an accident on the job or become ill and unable to work, call your supervisor.

33. Remember, you are a representative of our agency. People in the community judge the whole agency by the employee. You have the right to be proud of your work and the agency is proud of you.

34. All clients remain under supervision of a registered nurse who make supervisory visits in accordance with the agency policies. A registered nurse will always be available by telephone.

I have had an opportunity to ask questions regarding the above. I have read the instruction, understand them, and agree to abide by these rules.

Employee Signature _____ Date:

COMPLETE CARE CONNECT, LLC

Insurance Waiver

I, _____, waive all rights to transport any clients or people related to Complete Care Connect LLC. until I can provide a current copy of automobile insurance. I understand that all responsibility and consequences will be upon me if I go against those rules. Therefore, I give up all rights to sue or hold Complete Care Connect LLC. responsible for any damages or injuries.

Employee Signature _____ Date:

Administrative Signature _____ Date:

COMPLETE CARE CONNECT, LLC

Hepatitis B Vaccine Consent/Declination Form

All eligible (Hepatitis Bat risk) employees must sign ONE portion of this form stating whether they do or do not want Hepatitis B vaccine at this time or have records of prior vaccination.

Hepatitis B Vaccine Consent

I do wish to receive the Hepatitis B Virus (HBV) vaccine. I have read the attached information memorandum and understand it thoroughly. If I had further questions or concerns, I spoke with _____or my personal physician about them.

Print Name _____ SS # _____

Signature _____ Date: _____

Hepatitis B Vaccine Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccination at this time. I understand that by me declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. 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.

Print Name _____ SS # _____

Signature _____ Date: _____

Prior Vaccination or Immunity

I have completed the series of Hepatitis B vaccine (attach record of dates) or have attached documentation of prior immunity to Hepatitis B and do not wish to receive the vaccine at this time. I understand that I will be offered a booster free of charge if they are later recommended by the U.S. Public Health Service.

Print Name _____ SS # _____

Signature _____ Date: _____

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Complete Care Connect, LLC	**7658 Slate Ridge Blvd, Reynoldsburg, OH 43068**

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, sex, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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 05/31/2027

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*
Complete Care Connect, LLC		

Additional Information (Initial and date each notation.)

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2025

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.)

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (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)
Complete Care Connect, LLC 7658 Slate Ridge Blvd, Reynoldsburg, OH 43068		85-2516926

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

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 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 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 2025 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 17, 2026.

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. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

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

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

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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. Submit a separate Form W-4 for each job.

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 2025 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 2025 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:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 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	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

COMPLETE CARE CONNECT, LLC

Standard 207A Orentation Checklist

Employee: _____ Position: _____

ORIENTATION TO	Yes	No	Initial	Date
1. Basic Home Safety: bathroom, electrical, environmental and fire.	☐	☐		
2. Safety Program:	☐	☐		
a) Risks within agency and patient's home	☐	☐		
b) Actions to eliminate, minimize or report risks	☐	☐		
c) Incident Reporting and procedures to follow	☐	☐		
d) Reporting processes for common problems, failures and user errors	☐	☐		
3. Storage/handling/access to/ transport of supplies/medical gases/drugs	☐	☐		
4. ID/handling/disposal of infectious wastes (blood & body fluids/Precautions)	☐	☐		
5. ID/handling/disposal of hazardous waste (cytotoxic/chemotherapy drugs)	☐	☐		
6. Infection Control and Prevention	☐	☐		
a) Personal Hygiene (e.g. PPE & handwashing)	☐	☐		
b) Aseptic procedures	☐	☐		
c) Communicable infections (TB, AIDS, etc.)	☐	☐		
d) Cleaning/disinfecting reusable equipment	☐	☐		
e) Precautions to be taken (Standard Precautions, airborne transmission, direct/indirect contact, compromised immunity)	☐	☐		
7. Confidentiality of patient information/HIPAA policies and practices	☐	☐		
8. Community resources	☐	☐		
9. Policies/procedures	☐	☐		

COMPLETE CARE CONNECT, LLC

Standard 207A Orentation Checklist

ORIENTATION TO	Yes	No	Initial	Date
10. Responsibilities related to safety and infection control	☐	☐		
11. Advanced directives policies/procedures	☐	☐		
12. Specific job duties/responsibilities and any limitations; performance standards	☐	☐		
13. Screening for alleged or suspected victims of abuse/neglect reporting	☐	☐		
14. Emergency operations plan & role	☐	☐		
15. Equipment use/management relevant to job description	☐	☐		
16. Tuberculosis Program/Plan (OSHA)	☐	☐		
17. Hazardous Materials in the Workplace program (MSDS) (OSHA)	☐	☐		
18. Bloodborne Pathogen Program (OSHA)	☐	☐		
19. Managing the environment of care: (pt & Agency site)	☐	☐		
a) Safety	☐	☐		
b) Fire safety – fire escape, file alarm system, fire extinguishers – and prevention	☐	☐		
c) Security – Personal safety during home visits	☐	☐		
d) Utilities	☐	☐		
e) Responding to emergencies	☐	☐		
20. Pt rights/responsibilities	☐	☐		
21. Agency complaint mechanism/Medicare state hotline # and purpose	☐	☐		
22. PI program & role	☐	☐		
23. On-call & answering service	☐	☐		
24. Ethical aspects pf care, treatment and services and process to address ethical issues	☐	☐		

COMPLETE CARE CONNECT, LLC

Standard 207A Orentation Checklist

ORIENTATION TO	Yes	No	Initial	Date
25. Philosophy/mission/purpose/vision/goals	☐	☐		
26. Interpreters/communicating with hearing/speech/visually impaired	☐	☐		
27. Sentinel event policy/process	☐	☐		
28. Physical safety (e.g., body mechanics and safe lifting)	☐	☐		
29. Cultural diversity and sensitivity	☐	☐		
30. Role of the health team	☐	☐		
31. Family/State Medical Leave Act	☐	☐		
32. Organizational structure, line of authority & responsibility; supervision process	☐	☐		
33. Hours of work; benefits	☐	☐		
34. Documentation requirements	☐	☐		
35. Medical Device Reporting Act	☐	☐		
36. Equal Employment Opportunity Act	☐	☐		
37. Sexual Harassment Act	☐	☐		
38. Salary/hourly wage reimbursement	☐	☐		
39. Unemployment and Worker's Compensation	☐	☐		
40. Malpractice coverage	☐	☐		
41. Assessing and managing pain	☐	☐		

Other

Employee Signature _____ Date:

Supervisor Signature _____ Date:

Policies and Procedures Manual for Home Health Care © 2000 MED-PASS. Inc. (Revised 2009)

COMPLETE CARE CONNECT, LLC

Acknowledgment of Orientation (All Staff)

Please put your Initials on <u>EACH</u> line.

1. _____ I have received information concerning Organizational Structure, Agency Mission Statement, and Services Offered.
2. _____ I have received my job description and understand my relationship with other agency personnel.
3. _____ I have received and reviewed the Employee Handbook and will perform according to the guidelines outlined.
4. _____ I know where to find the Policy & Procedure manual and know the procedure for their retrieval and review.
5. _____ I understand my legal, ethical, and moral obligation to maintain confidentiality relating to our patients/clients and other agency documentation.
6. _____ I acknowledge that the agency maintains a drug-free workplace.

COMPLETE CARE CONNECT, LLC

Acknowledgment of Orientation (Clinical Staff)

Please put your Initials on EACH line.

1. _____ I understand that the agency is governed by State and Federal regulations and that I must perform according to these requirements.
2. _____ I understand the difference between a legal requirement and an ethical consideration.
3. _____ I am aware that maintaining a comfortable, safe, environment for all patients is one of my primary responsibilities.
4. _____ I understand the definition of an unusual occurrence and will report any to my supervisor immediately (incident reporting).
5. _____ I have reviewed a copy of the "Patient Bill of Rights" and understand my responsibility to the guidelines outlined.
6. _____ I understand Advance Directiveness and 'Do Not Resuscitate' orders. I understand how these affect the care I give to clients.
7. _____ I have reviewed the policy regarding:
    - Safety and Disaster Preparedness
    - Employee/Client Grievance Policy and Procedures
8. _____ I have reviewed and understand the significance of:
    - Criminal Background check
    - Sex Offender Registry
    - OSHA's Blood borne Pathogens Standards Patient Abuse Policy
9. _____ I understand how to:
    - Daily Report
    - Complete Time Sheets
    - Document all patient/client visits
    - Access medical supplies

Employee Signature _____ Date: _____

Agency Representative _____ Date: _____