

Application For Employment

Happy InHome Care Corp.

722 E. Main St, Suite 103
Leesburg, VA 20176

We are an Equal Opportunity Employer and is committed to excellence through diversity.

Please print or type. The application must be fully completed to be considered. Please complete each section, even if you attach a resume.

Personal Information

Name

Address		City	State	Zip
Phone Number	Mobile Number	Email Address		
Are You A U.S. Citizen? Yes <input type="checkbox"/> No <input type="checkbox"/>		Have You Ever Been Convicted Of A Felony? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If Selected For Employment Are You Willing To Submit to a Pre-Employment Drug Screening Test? Yes <input type="checkbox"/> No <input type="checkbox"/>				

Date Of Birth :

SS Number :

Position

Position You Are Applying For	Available Start Date	Desired Pay
Employment Desired <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal/Temporary		

Education

School Name	Location	Years Attended	Degree Received	Major

References

Name	Title	Company	Phone

Employment History

Employer (1)	Job Title		Dates Employed
Work Phone	Starting Pay Rate		Ending Pay Rate
Address	City	State	Zip
Employer (2)	Job Title		Dates Employed
Work Phone	Starting Pay Rate		Ending Pay Rate
Address	City	State	Zip
Employer (3)	Job Title		Dates Employed
Work Phone	Starting Pay Rate		Ending Pay Rate
Address	City	State	Zip
Employer (4)	Job Title		Dates Employed
Work Phone	Starting Pay Rate		Ending Pay Rate
Address	City	State	Zip
Employer (5)	Job Title		Dates Employed
Work Phone	Starting Pay Rate		Ending Pay Rate
Address	City	State	Zip

Signature Disclaimer

I certify that my answers are true and complete to the best of my knowledge.
If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Name (Please Print)

Signature

Date

<p>HAPPY INHOME CARE 722 East Market St, Suite 103, Leesburg VA 20176 510-460-8182/571-457-0367 Happyinhomecare3@gmail.com</p>	
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EMPLOYER & EMPLOYEE AGREEMENT

Employer:

Business Name: _____

Address: _____

Phone Number: _____ Fax Number: _____ Email Address: _____

Employee:

Last Name: _____ First Name: _____

Home Address: _____

Phone Number: _____ Cell Number: _____ Email Address: _____

The Parties agree as follows:

1. Duration of Contract

This contract shall have duration of _____ months from the date THE EMPLOYEE assumes his/her duties. The "TERM OF EMPLOYMENT")

Both parties agree that this contract is conditional upon THE EMPLOYEE obtaining a valid work permit pursuant to the Immigration Regulations.

2. Job Description

THE EMPLOYEE agrees to carry out the tasks as outlined in their job title/description.

3. Work Schedule

THE EMPLOYEE shall work _____ hours per week. He/she shall receive _____% more than the regular wages for any hours worked over this limit. His/her workday shall begin at _____ and end at _____, or, if the schedule varies by day, specify:

 THE EMPLOYEE shall be entitled to _____ minutes per day of break time (lunch, coffee breaks etc.....)

THE EMPLOYEE shall be entitled to _____ day(s) off per week, on _____

THE EMPLOYEE shall be entitled to _____ weeks of paid vacation.

THE EMPLOYEE shall be entitled to _____ days of sick leave per year.

4. Wages and Deductions

THE EMPLOYER agrees to pay THE EMPLOYEE, for his/her work, wages of \$_____ per week, or \$_____ per hour. These shall be paid at intervals of _____.

THE EMPLOYER is responsible for Income Tax Withholding, Social Security and Medicare taxes and Federal Unemployment Tax Act (FUTA).

THE EMPLOYER is responsible for depositing income tax withheld and both the employer and employee social security and Medicare taxes.

THE EMPLOYER shall not recoup from The Employee, through payroll deductions or any other means, any costs incurred in recruiting or retaining The Employee. These include, but are not limited to, any amounts payable to a third-party recruiter.

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If applicable, The Employer agrees to review and adjust (if necessary) The Employee's wages after 12 months of employment, to ensure they meet the prevailing wage rate for the occupation in the region.

5. Mileage Expenses

THE EMPLOYER agrees to pay The Employee 0.00 per mile for use of their own vehicle in the performance of their duties.

6. Workers' Compensation

THE EMPLOYER agrees to register THE EMPLOYEE under the appropriate state Workers' Compensation insurance plan.

THE EMPLOYER agrees not to deduct money from THE EMPLOYEE'S wages for this purpose.

7. Notice of Resignation

Should he/she wish to terminate the present contract, THE EMPLOYEE agrees to give THE EMPLOYER written notice thereof at least one week in advance.

8. Notice of Termination of Employment

THE EMPLOYER must give written notice before terminating the contract of THE EMPLOYEE if this employee has completed 3 months of uninterrupted service with THE EMPLOYER and if the contract is not about to expire. This notice shall be provided at least one week in advance.

9. Non-Solicitation of Clients

THE EMPLOYEE agrees not to solicit or accept independently any clients of THE EMPLOYER during their employment with THE EMPLOYER and for a period of ____ after termination of employment with THE EMPLOYER.

CONTRACT SUBJECT TO STATE LABOR AND EMPLOYMENT LEGISLATION

THE EMPLOYER is obliged to abide by the standards set out in the relevant state labor standards act. In particular, THE EMPLOYER must abide by the standards with respect to how wages are paid, how overtime is calculated, meal periods, statutory holidays, annual leave, family leave, benefits and recourse under the terms of the Act. Any terms of this contract of employment less favorable to THE EMPLOYEE than the standards stipulated in the relevant labor standards act is null and void.

IN WITNESS WHERE OF the parties state that they have read, understand and accepted all the terms and conditions stipulated in the present agreement/contract.

Signature of Employee

Date

Signature of Employer

Date



DECLINATION OF INFLUENZA VACCINATION

My employer or home care agency, _____, has recommended that I received influenza vaccination in order to protect myself and the clients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to prevent influenza disease and its complications, including death.
- If I contract influenza, I will shed the virus for 24-48 hours before influenza symptoms appear. My shedding the virus can spread influenza infections to clients.
- If I become infected with influenza, even when my symptoms are mild, I can spread severe illness to others.
- I understand that that the strains of virus that cause influenza infection change almost every year, which is why a different influenza vaccine is recommended each year.
- I cannot get the influenza disease from the influenza vaccine.
- The consequences of my refusing to be vaccinated could endanger my health and the health of those with whom I have contact, including:
 - clients
 - my co-workers
 - my family
 - my community

Despite these facts, I am choosing to decline influenza vaccination right now.

I understand that I may change my mind at any time and accept influenza vaccination, if vaccine is available.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Name (print) _____

Employee's Signature

Supervisor's Signature

HAPPY INHOME CARE CORP.
722 EAST MARKET ST SUITE 103
LEESBURG VA 20176
PH .510-460-8182

HAPPY INHOME CARE CORP

722 EAST MARKET STREET, SUITE 103 LEESBURG VA 20176

CRIMINAL HISTORY SEARCH CONSENT FORM

NAME: _____ DATE: _____

I, _____, have had no prior convictions of an offense which would bar or potentially bar employment as listed below:

CRIMINAL HOMICIDE

KIDNAPPING & FALSE IMPRISONMENT

INDECENCY WITH A CHILD

AGREEMENT TO ABDUCT FROM CUSTODY

SOLICITATION OF A CHILD

SALE OR PURCHASE OF A CHILD

ARSON

ROBBERY

AGGRAVATED ROBBERY

ASSAULTIVE OFFENSES

BURGLARY & CRIMINAL TRESPASS

THEFT

WEAPONS

FRAUD

PUBLIC LEWDNESS

INDECENT EXPOSURE

PUBLIC INDECENCY

A FELONY VIOLATION OF A STATUTE
INTENDED TO CONTROL THE POSSESSION
OR DISTRIBUTION OF A SUBSTANCE

I UNDERSTAND THAT THE HOME HEALTH AGENCY IS REQUIRED TO CONDUCT A CRIMINAL HISTORY CHECK BEFORE OFFERING ME EMPLOYMENT. I, THE UNDERSIGNED, HEREBY AUTHORIZE THIS AGENCY TO CONDUCT AND VERIFY MY CRIMINAL HISTORY BY PERFORMING A CRIMINAL HISTORY CHECK.

SIGNATURE OF EMPLOYEE

SIGNATURE OF SUPERVISOR

HAPPY INHOME CARE CORP
722 East Market St, Suite 103 Leesburg VA 20176
Kuldeep Guma/Harjit sodhi
510-460-8182/571-457-0367
Happyinhomecare3@gmail.com

CONSENT FOR TUBERCULIN SKIN TEST:-

LAST NAME _____ FIRST NAME _____ MI

ADDRESS _____ DATE OF BIRTH _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____

1. Have you ever had a TB Skin Test? Yes No
 2. Have you ever had a positive reaction to a TB Skin Test? Yes No
 3. Have you had any immunizations within the past six weeks? Yes No
- I Need to received TB Test to work as a PCA Personal care attendant For the Agency Good Home Health care.

Date _____

Signature of Patient or Guardian of Minor _____

Admin:-
Harjit Kaur _____

RECORD OF MANTOUX TEST:-
STEP 1

Date _____ Date Read _____ Result _____
Time _____ Time Read _____
TUBERSOL Lot # _____ Read by _____

HAPPY INHOME CARE CORP HOMECARE JOB DESCRIPTION

TITLE: Personal Care Aide

Supervisor : Administrator

POSITION SUMMARY :

Drives to patient homes and provide personal care and incidental light housekeeping services for the homebound patients.

PRINCIPAL DUTIES AND RESPONSIBILITIES:

Essential Functions:

1. Drives to patient's homes and provides personal care to patients as requested and specified by the nurse on the written plan of treatment. Such care includes assisting with or directly providing baths, mouth, nail, hair or skin care (including shaving) as well as providing assistance with/to the patient with activities related to dressing and toileting.
2. Assists patients with ambulation, transfer activities (using safety belt, may lift or pivot the patient and bear some weight) and the use of assistive devices (lie walkers, wheelchairs, commode, stools), brace s and prosthesis.
3. Performs special procedures with instruction and supervision by a nurse. These procedures include:
 - Taking vital signs and weight
 - Changing non-sterile dressings
 - Changing ostomy equipment
 - Assisting with bowel and bladder training
 - Measuring intake and output
 - Caring for in-dwelling urinary catheters
 - Assisting patients with self-administered medications
4. Observes patient's general health condition, including skin integrity, hygiene needs and tolerance to therapy activities and reports changes to the primary nurse.
5. Performs light housekeeping tasks for the patient as requested by the primary nurse on the written plan of treatment. These tasks may include making the patient's bed and changing the bed linen as needed, cleaning the patient's

HAPPY INHOME CARE CORP HOMECARE JOB DESCRIPTION

PHYSICAL DEMANDS:

Accurate communication in written or oral form, including telephone. Full range of body motion, proper body mechanics and strength to handle and lift patients. Lifting, bending, reaching, pulling and stooping required in providing care for patients. Independent travel to various patient homes.

WORKING ENVIRONMENT:

Works in a variety of home environments. Frequent travel. OSHA Category I (tasks involve exposure to blood, body fluids or tissue)

SUPERVISION RECEIVED:

Directly supervised and works independently under the Personal Care Manager with patient related work assignments supervised by the Administrator.

SUPERVISION EXERCISED:

None.

I have read and accept the above description of the duties and responsibilities, as well as the minimum requirements of this position. I understand that these duties and responsibilities may be augmented from time to time, based on office needs/requirements. I understand that this document does not create an employment contract and that I am employed by Angels Home Healthcare on an "at will basis".

Employee Signature

Date

I have reviewed the duties and responsibilities as described above with the above named employee.

Administrator

Date

HAPPY INHOME CARE CORP. HOMECARE JOB DESCRIPTION

supplies and care-related equipment, ensuring that the patient's environment is safe and clean and laundering patient's clothing and bed linen.

6. Assists patient with planning, preparing and shopping for meals. Feeds patient or assists
With feeding if necessary. Offers patient fluids in accordance with nurse instructions and cleans dishes and work area after meal preparation.
7. Reports changes in patient's condition to appropriate team or manager and participates in interdisciplinary communication.

OTHER JOB FUNCTIONS:

1. Participates in agency committees, staff meetings, in-services, performance improvement activities and other meetings as requested to maintain and upgrade level of knowledge and skills.
2. Adheres to agency policy and procedures.
3. Maintains patient, employee, and agency, confidentiality
4. Considered essential employee as it pertains to inclement weather.
5. Performs other duties as assigned.

MINIMUM QUALIFICATIONS:

EDUCATION: High School diploma or equivalent

CERTIFICATE/ LICENSE: - Registered by the Virginia Dept of health Professionals as Certified Nursing aide or
-Certificate of completion from Home Health Aide training program approved by the Virginia Department of Health .
-Nursing Aide training program approved by the Virginia Department of Education or Virginia Community College System or Virginia Department of Health Professions
-Current CPR certification
-Valid Driver's License with certificate of automobile insurance.

HAPPY INHOME CARE CORP

722 East Market Street, Suite 103, Leesburg VA 20176

510-460-8182/571-457-0367

Happyinhomecare3@gmail.com

HIPPA PRIVACY RULE EMPLOYEE CONFIDENTIALITY FORM

I have read and understand HAPPY INHOME CARE CORP, policies regarding the privacy of individually identifiable protected health information (PHI), as mandated by the health Insurance Portability and Accountability Act of 1996 (HIPPA) and the state of Virginia. In addition, I acknowledge that I have received training in C policies concerning PHI use, disclosure, storage and destruction as required by HIPPA.

In consideration of my employment or compensation from HAPPY INHOME CARE CORP I hereby agree that I will not at any time – either during my employment or association with HAPPY INHOME CARE CORP, or after my employment or association ends-use, access, or disclose PHI to any person or entity, internally or externally, except as is required and permitted in the course of my duties and responsibilities HAPPY INHOME CARE CORP P, as set forth in HAPPY INHOME CARE CORP, privacy policy and procedures or as permitted under HIPPA. I understand that this obligation extends to any PHI that I may require during the course of my employment or association with HAPPY INHOME CARE CORP, whether, written or electronic form and regardless of the manner in which access was obtained.

I understand and acknowledge my responsibility to apply HAPPY INHOME CARE CORP, policies and procedures during the course of my employment or association. I also understand that unauthorized use or disclosure of PHI will result in disciplinary action, up to and including termination of employment or association with HAPPY INHOME CARE CORP, and the imposition of civil penalties and criminal penalties under applicable federal and state law, as well as professional disciplinary action as appropriate.

I understand that this obligation will survive the termination of my employment or end of my association with HAPPY INHOME CARE CORP, regardless of the reason of such termination.

Print Name:- _____

Employee signature :- _____

Date:- _____

HAPPY INHOME CARE CORP

Employee Name: _____

Print Name

SEXUAL HARASSMENT

HAPPY INHOME CARE CORP does not tolerate **Sexual Harassment**, as it is a form of gender-based discrimination.

Definition:

Under Title VII of the Civil Rights Act of 1964, any type of discrimination based on an individual's gender (male or female) is illegal. Sexual harassment is considered to be a form of gender discrimination. According to the Equal Employment Opportunity Commission, sexual harassment is "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when submission to the conduct enters into employment decisions and/or the conduct unreasonably interferes with an individual's work performance or creates an intimidating, hostile, or offensive working environment."

The Agency will not tolerate any form of sexual harassment from any of its employees. The Agency encourages that any behavior which could be construed as sexual harassment be reported immediately to the supervisor and/ or Administrator. There is no need to fear retaliation. Both females and males can be sexually harassed when exposed to unwelcome sexual advances or to a pattern of verbal abuse, threatening, crude, impolite, or unprofessional conduct.

- Quid pro quo sexual harassment is also against company policy.
- The Agency encourages and urges an employee to come forward and discuss any sexual harassment that may have occurred with an Administrator.
- Every complaint will be taken seriously and investigated immediately. Investigations will be documented.
- Any employee involved a sexual harassment complaint will have a full opportunity to give a full account of their recollection of the incident or incidents.
- The incident(s) will be investigated thoroughly and appropriate action will be taken.

Employee Signature

Date

HAPPY INHOME CARE CORP

HBV VACCINE / WAIVER FORM

Employee Name: _____ Date of Hire: _____
Print Name

Social Security Number: _____

I understand that due to my occupation exposure to blood or other potential infectious materials I may be at risk acquiring Hepatitis B Virus (HBV) Infection. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself. I understand that by 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.

I have been advised of my rights to accept or decline the HBV Vaccine. HBV (Hepatitis B Virus) has been fully explained to me.

_____ I choose to waive my rights to receive the HBV Vaccine

_____ I choose to receive the HBV Vaccine and I understand that the vaccine is given in a 3 part series.

Series # 1 Date	Series # 2 Date	Series # 3 Date

Employee Signature

Date

Agency Rep. Signature

Date

HAPPY INHOME CARE CORP

722 EAST MARKET ST, SUITE 103, LEESBURG VA 20176

Tel # 571-457-0367

CRIMINAL HISTORY SEARCH CONSENT FORM

NAME: _____ DATE: _____

I, _____ have had no prior convictions of an offense which would bar or potentially bar employment as listed below.

CRIMINAL HOMICIDE

KIDNAPPING & FALSE IMPRISONMENT

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SOLICITATION OF A CHILD

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A FELONY VIOLATION OF A STATUTE
INTENDED TO CONTROL THE POSSESSION
OR DISTRIBUTION OF A SUBSTANCE

I UNDERSTAND THAT THE HOME HEALTH AGENCY IS REQUIRED TO CONDUCT A CRIMINAL HISTORY CHECK BEFORE OFFERING ME EMPLOYMENT. I, THE UNDERSIGNED, HEREBY AUTHORIZE THIS AGENCY TO CONDUCT AND VERIFY MY CRIMINAL HISTORY BY PERFORMING A CRIMINAL HISTORY CHECK.

SIGNATURE OF EMPLOYEE

SIGNATURE OF SUPERVISOR

Form W-4 (2018)

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

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at www.irs.gov/W4App to determine your tax withholding more accurately. Consider

using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at www.irs.gov/W4App to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at www.irs.gov/W4App to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. Head of household please note: Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

----- Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074 2018	
1 Your first name and middle initial		Last name		2 Your social security number	
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married filing separately, check "Married, but withhold at higher Single rate."			
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. <input type="checkbox"/>			
5 Total number of allowances you're claiming (from the applicable worksheet on the following pages)				5	
6 Additional amount, if any, you want withheld from each paycheck				6 \$	
7 I claim exemption from withholding for 2018, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here				7	
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
Employee's signature (This form is not valid unless you sign it.) ▶					
8 Employer's name and address (Employer: Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)		9 First date of employment		10 Employer identification number (EIN)	

Personal Allowances Worksheet (Keep for your records.)

- A** Enter "1" for yourself **A** _____
- B** Enter "1" if you will file as married filing jointly **B** _____
- C** Enter "1" if you will file as head of household **C** _____
- D** Enter "1" if:
 - You're single, or married filing separately, and have only one job; or
 - You're married filing jointly, have only one job, and your spouse doesn't work; or
 - Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.**D** _____
- E Child tax credit.** See Pub. 972, Child Tax Credit, for more information.
 - If your total income will be less than \$69,801 (\$101,401 if married filing jointly), enter "4" for each eligible child.
 - If your total income will be from \$69,801 to \$175,550 (\$101,401 to \$339,000 if married filing jointly), enter "2" for each eligible child.
 - If your total income will be from \$175,551 to \$200,000 (\$339,001 to \$400,000 if married filing jointly), enter "1" for each eligible child.
 - If your total income will be higher than \$200,000 (\$400,000 if married filing jointly), enter "-0-" **E** _____
- F Credit for other dependents.**
 - If your total income will be less than \$69,801 (\$101,401 if married filing jointly), enter "1" for each eligible dependent.
 - If your total income will be from \$69,801 to \$175,550 (\$101,401 to \$339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents).
 - If your total income will be higher than \$175,550 (\$339,000 if married filing jointly), enter "-0-" **F** _____
- G Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here . . . **G** _____
- H** Add lines A through G and enter the total here **H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed \$52,000 (\$24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

- 1** Enter an estimate of your 2018 itemized deductions. These 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. See Pub. 505 for details **1** \$ _____
- 2** Enter:
 - \$24,000 if you're married filing jointly or qualifying widow(er)
 - \$18,000 if you're head of household
 - \$12,000 if you're single or married filing separately**2** \$ _____
- 3** Subtract line 2 from line 1. If zero or less, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items) **4** \$ _____
- 5** Add lines 3 and 4 and enter the total **5** \$ _____
- 6** Enter an estimate of your 2018 nonwage income (such as dividends or interest) **6** \$ _____
- 7** Subtract line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses . . . **7** \$ _____
- 8** Divide the amount on line 7 by \$4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction **8** _____
- 9** Enter the number from the **Personal Allowances Worksheet**, line H above **9** _____
- 10** Add lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 **10** _____

HAPPY INHOME CARE CORP

Home Health Aide Competence Assessment Checklist

HOME HEALTH AIDE-

COMPETENCY ASSESSMENT METHOD- O – OBSERVATION, D-DOCUMENTATION, T-TEST

SKILLS

METHOD

SUPERVISOR

SKILLS	A	B	C	METHOD	COMPETENCY MET / NOT MET	SUP. INITIAL
COMMUNICATION SKILLS						
DOCUMENTATION OF PATIENT STATUS AND CARE						
RECORDING AND READING OF TEMPERATURE						
RECORDING AND READING OF RESPIRATION						
RECORDING AND READING OF PULSE						
INFECTION CONTROL PROCEDURES						
BODY FUNCTIONS AND CHANGES TO REPORT TO SUPERVISOR						
MAINTENANCE OF A CLEAN , SAFE AND HEALTHY ENVIRONMENT						
RECORDING EMERGENCY AND KNOWLEDGE OF EMERGENCY PROCEDURES						
PHYSICAL, EMOTIONAL NEEDS OF PATIENT AND MAINTAINING SAFETY, SECURITY, CONFIDENTIALITY OF THE PATIENT						

RN SIGNATURE-

DATE