

**Instant Care of Arizona, Inc.**  
**2601 E. Thomas Rd. #220**  
**Phoenix AZ 85016**  
**Email: info@instantcareaz.com**  
**Phone: 602-993-0297 / Fax: 602-993-0795**

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Dear Attendant Care Applicant:

Thank you for your interest in Instant Care of Arizona. If you are hired by Instant Care, you must meet the following requirements and have the following documents on file before being assigned to a member. We appreciate your assistance to ensure that if hired you have completed the following requirements. If you are not able to meet any of these requirements, please let us know.

**1. MUST HAVE RELIABLE CAR**

2. Complete an application for employment
3. Provide two (2) personal references (Instant Care will be calling and verifying references)
4. Provide one (1) previous employment reference, providing the name of an individual with supervisory authority (Instant Care will be calling and verifying references)
5. I-9 Employment Eligibility Verification. If you are hired, on the first day of employment you will need to provide proper document to complete the form I-9 that establish both identity and employment authorization. Proof of identity can include a driver's license or state issued identification card, passport, permanent resident card, social security card, birth certificate from U.S. state, or an employment authorization document from USCIS. A Complete list of acceptable documents are available on [www.uscis.gov/i-9-central/acceptable-documents](http://www.uscis.gov/i-9-central/acceptable-documents)
6. Provide CPR/ First Aid training certificate
7. Provide or take a TB test and/or CXR. (Chest X-Ray)
8. Pass a full Background Check
9. DCW Training (must be completed within 1 month of employment, once an interview is complete the applicant will be scheduled with the next upcoming DCW class)
10. Voided check for direct deposit (mandatory direct deposit)
11. Must wear scrubs and tennis shoes (closed toed shoes) while on duty, also must wear Instant Care Badge (family member caregivers are exempt)

This letter is to notify you of some of the requirements before being hired by Instant Care It is not an offer of employment. If hired by Instant Care, once you complete these requirements you will be eligible to be assigned to a member. Employment with Instant Care is at-will, meaning it can be terminated at any time, with or without cause and with or without notice. Completing the above requirements is not a guarantee of employment or continued employment with Instant Care.

Thank you for your application. If you have any questions about the above requirements, please do not hesitate to contact us.

Sincerely,  
Instant care of Arizona. Inc.

# Instant Care of Arizona, Inc. – Application for Employment

Instant Care of Arizona, Inc. is an Equal Opportunity Employer. We consider applicants for all positions without regard to race, color, religion, sex, national origin, age, marital or veteran status, disability, or other protected classifications.

Position(s) applied for \_\_\_\_\_ Date of application \_\_\_/\_\_\_/\_\_\_

Referral Source:

- Advertisement  Employee \_\_\_\_\_ NAME  Government Employment Agency  
 Walk-in  Relative \_\_\_\_\_ NAME  Private Employment Agency  
 Other \_\_\_\_\_

Name \_\_\_\_\_  
LAST FIRST MIDDLE

Other Names Used \_\_\_\_\_

Address \_\_\_\_\_  
STREET CITY STATE ZIP CODE

Telephone # ( ) \_\_\_\_\_ Alternate Phone # ( ) \_\_\_\_\_

May we contact you at work?.....  Yes  No

If yes, work number and best time to call ( ) \_\_\_\_\_ : AM/PM

If you are under 18 and it is required, can you provide a work permit?.....  Yes  No

If no, please explain \_\_\_\_\_

Have you previously submitted an application to Instant Care of Arizona, Inc.? .....  Yes  No

If yes, give date(s): From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Do you have friends or relatives working here?  Yes  No If yes, give name(s): \_\_\_\_\_

Have you ever been employed here before?.....  Yes  No

If yes, give date(s): From \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

Are you legally eligible for employment in this country?.....  Yes  No

Are you able to perform the essential functions of the job, with or without a reasonable accommodation?  Yes  No

Date available for work ..... / /

Type of employment desired  Full-Time  Part-Time  Temporary

What hours are you available for work? \_\_\_\_\_

Will you work overtime if required?.....  Yes  No

If no, please explain \_\_\_\_\_

Will you relocate if job requires it?  Yes  No Will you travel if job requires it?.....  Yes  No

Have you ever been convicted of or pled guilty or no contest to a felony (please exclude expunged or sealed convictions)?  Yes  No

If yes, please explain below: CONVICTION WILL NOT NECESSARILY BE A BAR TO EMPLOYMENT. EACH INSTANCE AND EXPLANATION WILL BE CONSIDERED IN RELATION TO THE POSITION FOR WHICH YOU ARE APPLYING.

Date of Conviction	Classification of Offense	Title and Description of Charges

Driver's license number if driving is an essential job function \_\_\_\_\_ State \_\_\_\_\_

# Employment History

Provide the following information for your past and current employers, assignments or volunteer activities, starting with the most recent (use additional sheets if necessary). Explain any gaps in employment. List all employment within the last \_\_\_\_\_ years.

EMPLOYER	TELEPHONE ( )	DATES EMPLOYED		SUMMARIZE THE TYPE OF WORK PERFORMED AND JOB RESPONSIBILITIES
		FROM	TO	
ADDRESS		MO/YR	MO/YR	
JOB TITLE		HOURLY RATE/SALARY		
		STARTING		
IMMEDIATE SUPERVISOR AND TITLE		\$	PER	
REASON FOR LEAVING		HOURLY RATE/SALARY		
		FINAL		
MAY WE CONTACT FOR REFERENCE?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> LATER	\$	PER	

EMPLOYER	TELEPHONE ( )	DATES EMPLOYED		SUMMARIZE THE TYPE OF WORK PERFORMED AND JOB RESPONSIBILITIES
		FROM	TO	
ADDRESS		MO/YR	MO/YR	
JOB TITLE		HOURLY RATE/SALARY		
		STARTING		
IMMEDIATE SUPERVISOR AND TITLE		\$	PER	
REASON FOR LEAVING		HOURLY RATE/SALARY		
		FINAL		
MAY WE CONTACT FOR REFERENCE?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> LATER	\$	PER	

EMPLOYER	TELEPHONE ( )	DATES EMPLOYED		SUMMARIZE THE TYPE OF WORK PERFORMED AND JOB RESPONSIBILITIES
		FROM	TO	
ADDRESS		MO/YR	MO/YR	
JOB TITLE		HOURLY RATE/SALARY		
		STARTING		
IMMEDIATE SUPERVISOR AND TITLE		\$	PER	
REASON FOR LEAVING		HOURLY RATE/SALARY		
		FINAL		
MAY WE CONTACT FOR REFERENCE?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> LATER	\$	PER	

EMPLOYER	TELEPHONE ( )	DATES EMPLOYED		SUMMARIZE THE TYPE OF WORK PERFORMED AND JOB RESPONSIBILITIES
		FROM	TO	
ADDRESS		MO/YR	MO/YR	
JOB TITLE		HOURLY RATE/SALARY		
		STARTING		
IMMEDIATE SUPERVISOR AND TITLE		\$	PER	
REASON FOR LEAVING		HOURLY RATE/SALARY		
		FINAL		
MAY WE CONTACT FOR REFERENCE?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> LATER	\$	PER	

**Gaps in Employment** (Account for all periods of unemployment of three months duration or more in the above employment history, excluding periods of time when you were a full-time student.)

From	To	State What You Were Doing
MO/YR	MO/YR	
MO/YR	MO/YR	
MO/YR	MO/YR	

## Educational Background

A. List last three (3) schools attended, starting with most recent. B. List number of years completed. C. Indicate degree or diploma earned, if any. D. Grade Point Average or Class Rank (if known). E. Major field of study. F. Minor field of study.

A. SCHOOL	B. NUMBER OF YEARS COMPLETED	C. DEGREE DIPLOMA	D. GPA/CLASS RANK	E. MAJOR	F. MINOR
Name City & State		TYPE YEAR			
Name City & State		TYPE YEAR			
Name City & State		TYPE YEAR			
Name City & State		TYPE YEAR			

## Skills and Qualifications

Summarize any special training, skills, licenses and/or certificates that may qualify you as being able to perform job-related functions in the position for which you are applying. You may wish to include foreign language skills, typing skills, PC skills, software used, office equipment, etc.

Do you have an HHA Home Health Assistance Certificate?  Yes  No      Do you have a CNA License? ....  Yes  No

Do you have a CPR Certification?  Yes  No      Do you have First Aid Certification?  Yes  No

Other training or skills: \_\_\_\_\_

## Additional Information

List professional, trade, business or civic associations, special accomplishments, publications or awards.

EXCLUDE MEMBERSHIPS AND INFORMATION WHICH WOULD REVEAL SEX, RACE, RELIGION, NATIONAL ORIGIN, AGE, COLOR, DISABILITY OR ANY OTHER SIMILARLY PROTECTED STATUS.

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List any additional information you should like us to consider: \_\_\_\_\_

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# Instant Care of Arizona Previous Employment Reference

## **SECTION A: TO BE COMPLETED BY APPLICANT**

Applicant's Name: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Employer's Phone Number: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **SECTION B: TO BE COMPLETED BY INSTANT CARE OF ARIZONA**

The person named above has made the application for employment with our company as a caregiver. We would appreciate your cooperation in answering these questions. All answers will be held confidential to the extent permitted by law.

1. Date Hired: \_\_\_\_\_
2. Date Terminated: \_\_\_\_\_
3. Position Held: \_\_\_\_\_
4. Reason for Leaving: \_\_\_\_\_
5. How would you rate this person in the following characteristics?

Please Circle:

Dependability:	Excellent	Above Avg.	Acceptable	Poor
Punctuality:	Excellent	Above Avg.	Acceptable	Poor
Trustworthiness:	Excellent	Above Avg.	Acceptable	Poor
Enthusiasm	Excellent	Above Avg.	Acceptable	Poor
Interaction with others	Excellent	Above Avg.	Acceptable	Poor

6. Would you hire this person again? \_\_\_\_\_
7. Would you recommend this person as a caregiver? \_\_\_\_\_
8. What was the person's greatest strength/weakness? \_\_\_\_\_
- 9: Are there any issues regarding this individual you as an employer would want to be aware of if you were hiring this individual? \_\_\_\_\_

Confirmed By Staff Member:	<i>Office Use Only</i>	Today's Date:
_____		_____

# Instant Care of Arizona Personal Reference

## SECTION A: TO BE COMPLETED BY APPLICANT

Applicant's Name: \_\_\_\_\_

Reference's Name: \_\_\_\_\_

Reference's Phone Number: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## SECTION B: TO BE COMPLETED BY INSTANT CARE OF ARIZONA

The person named above has applied for employment with our company as a caregiver and listed you as a personal reference. We would appreciate your cooperation in answering the following questions. All answers will be held in the greatest confidence permitted by law.

1. How long have you known the applicant? \_\_\_\_\_
2. In what capacity do you know this person? \_\_\_\_\_
3. What do you enjoy most about this person? \_\_\_\_\_  
\_\_\_\_\_
4. What do you consider his/her greatest strength? \_\_\_\_\_  
\_\_\_\_\_
5. What do you consider his/her greatest weakness? \_\_\_\_\_  
\_\_\_\_\_
6. How well does the applicant relate to other people? \_\_\_\_\_
7. Would you recommend this person as a personal caregiver? (if no please explain): \_\_\_\_\_  
\_\_\_\_\_
8. How would you rate this person in the following characteristics?  
Please Circle:

Dependability:	Excellent	Above Avg.	Acceptable	Poor
Punctuality:	Excellent	Above Avg.	Acceptable	Poor
Trustworthiness:	Excellent	Above Avg.	Acceptable	Poor
Enthusiasm:	Excellent	Above Avg.	Acceptable	Poor
Interaction with others	Excellent	Above Avg.	Acceptable	Poor

Confirmed by Staff Member:

*Office Use Only*

Date:

\_\_\_\_\_

\_\_\_\_\_

## Instant Care of Arizona Personal Reference

### SECTION A: TO BE COMPLETED BY APPLICANT

Applicant's Name: \_\_\_\_\_

Reference's Name: \_\_\_\_\_

Reference's Phone Number: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### SECTION B: TO BE COMPLETED BY INSTANT CARE OF ARIZONA

The person named above has applied for employment with our company as a caregiver and listed you as a personal reference. We would appreciate your cooperation in answering the following questions. All answers will be held in the greatest confidence permitted by law.

1. How long have you known the applicant? \_\_\_\_\_
2. In what capacity do you know this person? \_\_\_\_\_
3. What do you enjoy most about this person? \_\_\_\_\_  
\_\_\_\_\_
4. What do you consider his/her greatest strength? \_\_\_\_\_  
\_\_\_\_\_
5. What do you consider his/her greatest weakness? \_\_\_\_\_  
\_\_\_\_\_
6. How well does the applicant relate to other people? \_\_\_\_\_
7. Would you recommend this person as a personal caregiver? (if no please explain): \_\_\_\_\_  
\_\_\_\_\_
8. How would you rate this person in the following characteristics?  
Please Circle:

Dependability:	Excellent	Above Avg.	Acceptable	Poor
Punctuality:	Excellent	Above Avg.	Acceptable	Poor
Trustworthiness:	Excellent	Above Avg.	Acceptable	Poor
Enthusiasm:	Excellent	Above Avg.	Acceptable	Poor
Interaction with others	Excellent	Above Avg.	Acceptable	Poor

Confirmed by Staff Member:

*Office Use Only*

Date:

\_\_\_\_\_

\_\_\_\_\_

# COMMUNICATION

## MESSAGE

SEND -----RECEIVE

- FACIAL EXPRESSION.
- EYE CONTACT .
- POSTURE.
- HAND GESTURES.
- DISTANCE.
- TOUCH.
- BODY MOVEMENT



## GUIDELINES FOR ATTENDANTS WHILE ON DUTY

- You need to report to your supervisor if your client is hospitalized, you can accompany your client to the hospital and stay until your hours are over or your time automatically ends when your client is admitted. When your client returns home you cannot go back to work without your supervisor's permission. Even if the client calls you and tells you they are home from the hospital, you cannot go back to work until your supervisor tells you to. Please call your supervisor.
- Take direction for your client's care from your supervisor. Your supervisor is the only person who can change or add to your hours. If your client's hours change please call your supervisor before making any changes in your hours.
- You need to notify your supervisor of any changes in your client's condition for example skin changes; client falls; changes in client's speech; medications etc.
- Report any unsafe conditions in your client's home immediately, call the supervisor on duty. For example no running water; no food in the refrigerator; no electricity etc.
- Report any injuries to you or your client, immediately call the supervisor on duty.
- You are not allowed to change bandages, cleanse wounds, call in prescriptions or pick-up over the counter medicine such as aspirin, Advil, suppositories, cough medicine etc.
- You can only be in your client's home when your client is there. The exception is client specific.
- Affectionate relationships with your client or their family are not allowed. Carrying any type of weapon on the job is not allowed. Having keys to your client's home is allowed **only when an agreement is signed by your client, your supervisor and you, otherwise having keys to your client's home is not allowed.** The above can cause disciplinary action up to and including termination.

- You are required to wear your badge and dress according to the dress code policy, attending trainings, or whenever you come into the office. Your badge is the only form of identification accepted when picking up your check.
- You need to be on time to your client. If you are going to be late even ten minutes you must call your client to let them know, then call the office and leave your supervisor a message. If you are a NO CALL or NO SHOW to your client it can cause disciplinary action, up to and including termination
- You are required to give the Attendant Care Program 2 hours notice when calling off. Please call the staffing office (602) 003-0297 between 7:30am-4:30pm Monday through Friday or the on call pager when the office is closed (602) 993-0297 after the beep dial in your phone number and press the # sign someone will call you back if you do not press the # sign your call will not go through.
- If someone is dropping you off please have him or her leave immediately or if picking you up, please have him or her come at the end of your shift no sooner.
- All cell phones must be put on vibrate. Only emergency phone calls can be returned. Please inform your client of your need to return the phone call. Step outside when returning a personal call. If you need to use the client's phone please ask their permission.
- Do not give out your personal phone numbers to your client or their family. Please keep your personal problems to yourself.
- Expect unannounced visits from your supervisor.

## **GUIDELINES FOR ATTENDANTS WHILE ON DUTY**

- You are not to eat the client's food. Please bring your food with you.
- Some clients are sensitive to certain smells, such as perfume, lotions, etc. Please use caution when using these products.
- You cannot bring family, children, or pets to work.
- You may not borrow anything from your client or their family this includes money, food, appliances, clothing, etc.
- You may not drive your client in your car.
- You may not driver your client's car.
- You cannot smoke in your client's home, even if the client does.
- You do not move furniture, clean ceiling fans, wash walls or clean the outside of windows, clean up after animals, baby-sit children, pain, do any kind of yard work or clean up after family members.
- Remember you are a caregiver not a maid. Your job makes a difference in a client's life. When you have a problem we need to know so we can assist you in solving the problem. We care about you. Please report by way of your Client Care Supervisor any problems or concerns you have. Always show respect for your client and their family.

**My signature below indicates I have read and understand my job responsibilities. A copy will be kept on file.**

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**Signature**

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**Print Your Name**

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**Date**

**AS AN APPLICANT I UNDERSTAND AND AGREE TO THE FOLLOWING:**

**Instant Care of Arizona, Inc.** ("the Company") does not discriminate in hiring or employment on the basis of race, color, religion, sex, national origin, age, disability, veteran status or status within any other protected group. No questions on this application are intended to secure information to be used for such discrimination. Pursuant to the Americans With Disabilities Act, it is the Company's policy to hire qualified individuals with a disability as long as the individual can perform the essential functions of the job, with or without a reasonable accommodation.

In connection with the Company's consideration of me for employment, continued employment, promotion or reassignment or as part of an investigation, I understand that the Company or persons acting on its behalf may conduct investigative inquiries into my background that will include information regarding job reference, personal reference, criminal, consumer credit, driving, and other reports pertaining to me. These inquiries may include personal conversations with persons possessing knowledge relevant to these categories. These background inquiries will be conducted and reports obtained to provide the Company with job-related information regarding my character, general reputation, personal characteristics, work record and characteristics, skills and abilities, education and training, employment and experience, past job performance, reasons for termination of previous employment and other pertinent information.

I hereby consent to the Company, or persons acting on its behalf, obtaining the above stated information, I authorize, without reservation, any person or entity contacted by the Company or anyone acting on its behalf to furnish the above-stated information, and I release any such person or entity from any and all liability for furnishing such information. I also release the Company from any and all liability for conducting such an investigation. I understand that I have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of the investigation(s).

In addition to authorizing the release of any information regarding my employment and background, I hereby fully waive any rights or claims that I have or may have against my former employers, their agents, employees and representatives regarding the release of information and release them from any and all liability, claims, or damage that may directly or indirectly result from the use, disclosure, or release of any such information by any person or party, whether such information is favorable or unfavorable to me.

I authorize the Company or persons acting on its behalf to make these investigations, and to use job-related information obtained in its employment decision, including but not limited to, the truthfulness of my responses to the Company's employment inquiries. I hereby state that all information that I provide on this application and in any interview is true and accurate. I am aware that false statements, misrepresentations of facts, or material omissions may be sufficient to disqualify me for employment, or if employed, may result in my termination.

I have not signed any employment agreement or other agreement which limits the type of job I might accept in the future, or which limits for whom I might work in the future, with any employer by whom I have been employed at any time during the past two (2) years. If a job offer is extended, my initial and continued employment will be conditioned upon execution of agreements, if appropriate, with regard to invention, patent, confidentiality and non-competition. As part of the pre-employment process, I understand that I may be required to submit to a drug test.

If employed, I will be required to provide proof of identity and legal work authorization, and I must meet minimum age requirements of applicable laws. I understand and acknowledge that there have been no oral or written representations made promising or guaranteeing employment or continued employment.

I understand that nothing contained in this application, offer letter, or in the interview process is intended to create an employment contract between the Company and me. If I am employed, I have a right to terminate my employment at any time and for any reason. Similarly, the Company may terminate my employment at any time, with or without notice and with or without cause. The Company is an at-will employer. I further understand that no representative of the Company has any authority to enter into any agreement with me for any specified period of time or to guarantee some other benefit, other than the President and any such agreement must be in writing to be effective. Supervisors do not have authority to make oral agreements guaranteeing employees' future promotions, pay raises, benefits, reassignments or transfers. Any such assurances must be in writing and signed by the President to be enforceable. This statement applies to the period prior to or after I may be employed.

I understand that my application for employment will be considered active for 60 days. After the expiration of 60 days, and, if I still desire to be considered for employment, it will be necessary for me to complete a new application.

Signature of Applicant: \_\_\_\_\_

Applicant Name: \_\_\_\_\_

Date: \_\_\_\_\_

(Print)

## TRANSPORTATION OF CLIENT/MEMBERS

Instant Care of Arizona provides care and companionship services to clients. While we provide a broad range of services, Instant Care DOES NOT provide transportation services. Employees are strictly prohibited from transporting clients in the employee's personal vehicle or in the client's vehicle or any other vehicle. You may accompany the client as a passenger if the client is being transported by an independent transportation service to doctor's appointments or other appointments, but employees are strictly prohibited from driving clients while on working hours for any reason.

Driving or transportation is not a service offered by Instant Care and Instant Care does not have any liability or responsibility to the employee or client if employee violates this policy. Employee may be held liable for all damages and expenses involved if they are transporting a client in violation of this policy and are in an accident.

Employees who are providing care and companionship to family members are subject to this policy and may not transport clients during working hours. If the family member employee provides transportation to a family member client during working hours, it is a violation of this policy and grounds for disciplinary action, up to and including termination of employment.

### Employee Acknowledgment

I understand and agree that I am not permitted to transport clients during my working hours, either in my personal vehicle, the client's vehicle, or any other vehicle. I agree not to drive the client around for any reason while on working hours. I understand and agree that if I provide transportation or driving services to a client in violation of this policy, I will be solely liable for any damages and the Company will not be liable for any damages or costs that may result from my violations of this policy.

If I am providing care and companionship services to a family member, I understand that any transportation of my family member should be done outside of working hours. I expressly understand and agree that when transporting a family member for any reason, I am acting as a family member of the client, not as an employee of Instant Care. I understand and agree that I will be solely liable for any damages and the Company will not be liable for any damages or costs that may result from my violations of this policy.

I understand and agree to comply with the Company's policies, practices, and procedures. I further understand and agree that I am an at-will employee, meaning that the Company or I can terminate my employment at any time, for any reason, with or without notice and with or without cause.

Name (Print) \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Instant Care of Arizona

### *CULTURAL DIVERSITY AND SENSITIVITY*

Each person represents a mixture of cultures and experiences. Diversity refers to all the ways that individuals are unique and different from one another. Some elements of diversity are age, gender, race, physical ability, physical characteristics, personality type and religious beliefs.

Communication and working relationships of different cultures require mutual respect and some understanding of another culture. There are over 6,000 communities and languages in the world. Differences lead to diversity of vision, values, beliefs, practices, and expression. Every culture deserves equal respect and dignity.

Attendants should respect differences, learn about other cultures and their practices, and accept that there are many ways to view the world. There are many ways to demonstrate respect for other cultures, including but not limited to:

- Do not treat others as you want to be treated. Learn how **THEY** want to be treated. What is polite and proper in one culture may be considered rude or uncaring in another culture.
- Always use surnames unless you are given permission to use a person's first name.
- Learn about people's traditions regarding holidays and respect that by not saying things like "Merry Christmas" to people who do not celebrate the Christmas holiday.
- When working in a Hindu household, removing your shoes before entering their home is showing respect for the family.
- In the Chinese culture when greeting the family you show respect by nodding your head as you say good morning.

As an attendant working in these environments you need to be aware that there will be differences. You should ask, "Are there any special customs that you would like me to be aware of?" This is an opportunity to learn more about different customs and show respect for a culture that may differ from yours.

I understand and agree that awareness of and sensitivity to cultural differences is a key aspect of my job. I commit to learning and respecting the cultural differences of my clients. I also understand and agree that I am an at-will employee, meaning that the Company and I can terminate my employment at any time, with or without notice and with or without cause.

Employee's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Instant Care of Arizona Member's Rights and Responsibilities

## **RIGHTS AS A MEMBER OF THE INSTANT CARE PROGRAM:**

- ❖ To be treated with dignity, respect, and consideration;
- ❖ To not be treated unfairly because of your race, religion, gender, age, disability, or financial status;
- ❖ To have all personal information about you kept confidential, including but not limited to financial and social information;
- ❖ To have all medical and treatment information and records kept confidential;
- ❖ To receive care of the highest quality;
- ❖ To request a change in care providers;
- ❖ To have private conversation and communication with the Member Care Supervisor or other management and support staff of the Instant Care Program; and
- ❖ To be given information regarding the complaint process and to file a complaint without fear of reprisals or interference with service, and to be provided information about the disposition of any complaint.

## **RESPONSIBILITIES AS A MEMBER OF THE INSTANT CARE PROGRAM:**

- ❖ To treat Instant Care program personnel with respect and consideration;
- ❖ To provide a safe home environment in which your care can be provided and received;
- ❖ To participate in planning the care and in planning changes in the care provided by your attendant and receive an explanation of any proposed services;
- ❖ To provide accurate and complete information about matters related to your health and any changes to your medical condition;
- ❖ To call the Member Care Supervisor, if you have any problems with our attendant or if there is a misunderstanding or confusion over the attendant's duties.
- ❖ To notify your Member Care Supervisor as soon as possible, if you are not going to be home for your visit; and
- ❖ To notify your Member Care Supervisor as soon as possible of any change of address or phone number.

Employee's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Instant Care

## Instant Care of Arizona EMPLOYEE TIME MANAGEMENT GUIDE

It is important that employee's manage their time with the member to ensure that the member's needs are met. To ensure that all tasks are properly completed, the attendant should set up a schedule with the member and block out activities in time slots that estimate the time needed to complete each task. As an attendant you need to ensure that you are on time and also ensure that your member is on time for medical appointments, etc.

The member's needs are important therefore, we have made the schedule with enough dedicated time for all the duties. For any questions regarding the schedules please call the office.

Tips to improve if you find that you are not completing all tasks.

1. Create a "to do list". Having a list of defined tasks and understanding what you need to achieve will help you manage your time more efficiently. Schedule the tasks from your "to do list" on a calendar or organizer.
2. Learn to prioritize. Complete the most important tasks first. Make sure to prioritize the tasks that are most important to the member and to the member's health and well-being, including doctor's appointments, etc.
3. Combine several activities. For example, socialize with the member while folding laundry or cooking. Make the beds while a load of laundry is in the washer. Do not, however, let yourself become distracted such that you start several tasks and do not complete any.
4. Set a time limit for each task. For example, focus on meal planning and preparation that can be completed in 30 minutes.
5. Make it work. The member relies on you.

I understand that time management is an essential function of my position as an Attendant and I commit to utilizing the best time management techniques and provide the best possible care to my members. I agree to comply with the Company's policies and procedures. I further understand and agree that I am employed at will, meaning that either the Company or I can end my employment at any time, for any reason or no reason, with or without notice and with or without cause.

Employee's Name (print): \_\_\_\_\_

Employee's Signature: \_\_\_\_\_

Today Date: \_\_\_\_\_



## **Instant Care of Arizona**

### **Documentation of Direct Care Worker (DCW) Training**

Attendant must complete DCW training within 90 days of their effective date of employment. The DCW class is a state mandatory class. DCW classes are held in our office. If you have any questions regarding DCW classes please contact our office staff.

During the DCW class you will cover the following:

- ❖ Roles and Responsibilities within the Agency and Community
- ❖ Ethical and Legal Issues
- ❖ Communication and Cultural Competency
- ❖ Job Management Skills/Time Management
- ❖ Infection Control
- ❖ Safety and Emergencies Nutrition and Food Preparation
- ❖ Home Environment Maintenance
- ❖ Chronic Diseases and Physical Disabilities
- ❖ Philosophy and Values of Providing Care and Support
- ❖ Physical and Emotional Needs of an Individual
- ❖ Transfers and Positioning
- ❖ Personal Care
- ❖ Activities and Activity Planning
- ❖ Dementia-Specific Care
- ❖ Grief and End-of-Life Issues

I understand and agree that it is my responsibility to become proficient in the competencies listed above. I agree to comply with all company policies, practices, and procedures. I further understand that violations of the company's policies, practices, and procedures may lead to disciplinary action up to and including termination of employment.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

This Documentation of Attendant Training and Education will be placed in the Attendant's personnel file. Attendant training is a required condition of employment with the Company.

# Instant Care of Arizona Inc

## Orientation Checklist

Please go to [InstantCareaz.com](http://InstantCareaz.com) and click on the careers page to find your **Orientation Packet**. If you do not have internet access please notify a staff member and one will be provided to you.

**Employee Name:** \_\_\_\_\_ **Date Completed:** \_\_\_\_\_

	<b>Initial Box</b>
Philosophy and Mission Statement	_____
Services Offered	_____
Policy & Procedures Review & Knowledge of Manual	_____
Clients Rights &C advance Directives	_____
Clients Rights & Advance Directives	_____
Ethical Issues in Client Services	_____
Infection Control	_____
OSHA Requirements	_____
Performance Expectations & Performance Evaluations	_____
Documentation in Service Records	_____
Job Description Including Health Requirements	_____
Employee Standards and Discipline	_____
Cultural Diversity and Sensitivity	_____
Time Management	_____

**Employee's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# Instant Care of Arizona

## Documentation of Attendant Training Education

This form is used to record training and education received by the Attendant. Attendant must complete training in all of the core competencies listed below. If you have any questions regarding any training, please contact the office.

### COMPETENCIES:

- Member Rights and Responsibilities
- Communication Skills
- Identification of medical changes in member
- Time Management
- Cultural Diversity and Sensitivity

I understand and agree that it is my responsibility to become proficient in the competencies listed above. I agree to comply with all company policies, practices, and procedures. I further understand that violations of the company's policies, practices, and procedures may lead to disciplinary action, up to and including termination of employment.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

This Documentation of Attendant Training and Education will be placed in the Attendant's personnel file. Attendant training is a required condition of employment with the Company.

# Instant Care of Arizona Health Insurance Marketplace Coverage Options and Your Coverage

## PART A: General Information About the Marketplace

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

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins on November 15, 2014 for coverage starting as early as January 1, 2015.

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

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

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

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

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

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description at [www.instantcareaz.com/careers](http://www.instantcareaz.com/careers). The summary plan description contains information about the health coverage offered by the Company that will be necessary if you apply for health care through the Marketplace.

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

## PART B: Information about Health Coverage Offered by Instant Care of Arizona

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

- As your employer, we offer a health plan to:  
 All employees. Eligible employees are:

Some employees. Eligible employees are all full-time employees. Full-time employee is defined as an employee who works an average of 30 hours or more per week or 130 hours or more per month.

- With respect to dependents:  
 We do offer coverage. Eligible dependents are children up to age 26 and spouses:

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

### ACKNOWLEDGMENT OF RECEIPT

\_\_\_\_ (Initial) I acknowledge that I have access to the following compliance notices or documents for our annual Open Enrollment: Summary of Benefits and Coverage (SBC), HIPPA Notice of Special Enrollment Rights, WHCRA, CHIP, Exchange Notice and Medicare Part D Notices, and ERISA Wrap Document at [www.instantcareaz.com/careers](http://www.instantcareaz.com/careers).

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date \_\_\_\_\_

## **SICK LEAVE POLICY AND ACKNOWLEDGMENT**

### **INSTANT CARE OF ARIZONA, INC.**

Employees are eligible for earned paid sick time (PST) of up to forty (40) hours per year, in compliance with the 2017 Fair Wages and Healthy Families Act. PST is awarded at the rate of one (1) hour of sick time for every thirty (30) hours worked, up to a maximum of forty (40) hours per year and based on the fiscal year July 1 through June 30.

Up to forty (40) hours of sick time may be used per calendar year. Remaining sick time may roll over for use in the following leave year, however time in excess of forty (40) hours will be eliminated at the end of each year. Employees are limited to using forty (40) hours of PST per calendar year.

PST is awarded from the date of hire, but new employees must work for ninety (90) days before they can use paid sick time.

PST may be used for yourself or the care of a family member for the following purposes:

- (1) Medical care or mental or physical illness, injury, or health condition;
- (2) A public health emergency; and
- (3) Absence due to domestic violence, sexual violence, abuse, or stalking.

PST is not part of overtime calculations; it is paid at the base straight-time rate of pay in effect when the PST is taken. It can be taken in one hour increments.

To ensure customer service and smooth business operations and as a courtesy to coworkers, employees should schedule foreseeable time off, such as medical appointment or appointments relating to domestic violence, sexual violence, abuse or stalking for the employee or a family member, as far in advance as possible and make a reasonable effort to schedule PST in a manner that does not unduly disrupt the Company's operations. In case of an emergency or illness, employees should notify their supervisor at least two hours in advance of their scheduled shift or as soon as practicable. Employees may provide notice of the intended use of PST in person, verbally, by phone, electronically, or in writing.

For absences of three days or more, the Company may require reasonable documentation of the reason. Employees must be accurate and truthful regarding the use of PST. Honesty and integrity in using company benefits is important, as is keeping accurate time records. Violations of Company policies, practices, and procedures may lead to disciplinary action up to and including termination of employment.

Unused sick time is not paid out upon separation of employment. This is a use-it-or-lose-it policy. If an employee is rehired within nine months, the Company will reinstate unused sick time.

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**Acknowledgment:**

I hereby acknowledge that I have received and reviewed a copy of the Company's Paid Sick Time (PST) Policy and the Paid Sick Time Notice. I understand and agree that I must comply with the notice provisions in the PST policy and to work with the Company to schedule foreseeable leave in a manner that does not unduly disrupt business operations. I further understand and agree that I may use PST only for authorized purposes, and that I must be truthful and accurate regarding the reasons I am requesting leave. I understand and agree that I must be honest and accurate in using sick leave or other Company benefits and in all of my interactions with the Company. Violation of Company policies, practices, or procedures may result in disciplinary action, up to and including termination of employment.

I understand and agree that I will comply with the Company's policies, practices, and procedures. I further agree that am employed at-will, meaning that either the Company may separate my employment at any time, for any reason or no reason, with or without notice and with or without cause.

Employee Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Instant Care of Arizona**  
**Disclosure and Consent to Obtain Consumer Report For Employment Purposes**

Instant Care of Arizona, Inc. (the “Company”) requires that you agree to a thorough background check, also known as a “consumer report,” in order for you to be considered for initial hiring, promotion, reassignment or retention by the Company. A consumer report contains information about your personal and credit characteristics, character, general reputation, mode of living, bank information, and public record information, including any record of criminal conduct and motor vehicles records. The Company requires that you agree to allow the Company to obtain a consumer report at any time during your employment with the Company.

I authorize and instruct the Company to obtain a Consumer Report about me both for initial hiring and at any time during my employment with the Company. I further authorize and consent to the Company obtaining and using a consumer report both for evaluating my application for employment and, if hired, in connection with any future decisions regarding my employment with the Company. I authorize and instruct any and all consumer and/or credit reporting agencies to provide such consumer reports as the Company deems necessary or prudent and as allowed by the Fair Credit Reporting Act.

I further acknowledge that I have carefully read and fully understand the contents of this document, and that I understand that an analysis of any consumer report by the Company may affect its decision whether or not to offer employment to me or continue to employ me.

I knowingly and voluntarily agree to release and hold harmless the Company, its officers, trustees, agents and employees from and against any and all liability resulting from any decision regarding my employment with the Company, which are based in good faith upon any consumer report.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant

\_\_\_\_\_  
Date of Birth of Applicant\*

\_\_\_\_\_  
Social Security Number of Applicant\*

\_\_\_\_\_  
Drivers license number, expiration date, and State of issue\*

\*The information provided on this document will be used for the sole purpose of conducting a background check and will not be used for any other employment related purpose.



**INSTANT CARE OF ARIZONA**

**PAYROLL DEDUCTION AUTHORIZATION  
FOR COST OF BACKGROUND CHECK**

I understand and agree that Instant Care may deduct money from my check (whether I am paid by direct deposit or check) in an amount equal to the Company's cost of completing a background check on me. I understand and agree that Instant Care may deduct the amount owed from a single paycheck or from several paychecks, but that the deduction will not bring my gross pay below minimum wage (and overtime if applicable) for all hours I work during a pay period.

Pursuant to this form, I authorize the Company to deduct from my first paycheck (and subsequent paychecks if necessary) the amount of \$33.00.

I agree to comply with the Company's policies, practices, and procedures. I understand that I am an at-will employee and the Company and I both have the right to terminate my employment at any time, for any reason or no reason, with or without cause, and with or without notice.

Employee Name (Print): \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**HEPATITIS B VACCINATION**

**EMPLOYEE ACCEPTANCE/DECLINATION**

**EMPLOYEE NAME:** \_\_\_\_\_

**EMPLOYEE NUMBER:** \_\_\_\_\_

**I UNDERSTAND** that due to my occupational exposure to blood or other potentially infectious materials, **I may be at risk** at acquiring the Hepatitis B virus (HBV) infection.

**I HAVE BEEN GIVEN THE OPPORTUNITY** to be vaccinated with the Hepatitis B vaccine, at no charge to me.

**I HAVE READ AND UNDERSTAND** all the information contained on the *Hepatitis B Vaccination Fact Sheet*

ACCEPTANCE	DECLINATION
<p>I, _____, have been provided with updated information of the Hepatitis B vaccine. I have had the opportunity to ask questions about the benefits and risk of the Hepatitis B vaccination. I also understand that there are no quarantines that I will become immune and that there is a possibility that I will experience an adverse side effect from the vaccine.  <b>FOR WOMEN: I have been advised</b> that studies have not been conducted to determine the effects of the vaccine on a developing fetus. Therefore, the safety of the Hepatitis B vaccine relating to the developing fetus is currently unknown.</p>	<p>I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring the Hepatitis B virus (HBV) infection.  <b>I have been given the opportunity</b> to be vaccinated with Hepatitis B vaccine, at no charge to me. <b>I decline Hepatitis B vaccination at this time.</b>            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 want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination at no charge to me.</p>
<p><b>Employee Signature:</b>  <b>Date:</b></p>	<p><b>Employee Signature:</b>  <b>Date:</b></p>
<p><b>Witness Signature:</b>  <b>Date:</b></p>	<p><b>Witness Signature:</b>  <b>Date:</b></p>

**EXEMPTION**

**I have been given the opportunity to be vaccinated, however, I cannot accept the vaccination at this time because:**

I have been previously vaccinated against Hepatitis B. I received my last dose on: \_\_\_\_\_

I am currently immune to Hepatitis B in accordance with antibody testing performed on: \_\_\_\_\_

I cannot take Hepatitis B vaccine because I have an allergy/hypersensitivity to the component(s) of the vaccine.

**Employee Signature:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Type or print your Full Name		Your Social Security Number
Home Address – number and street or rural route		
City or Town	State	ZIP Code

**Choose either box 1 or box 2:**

- 1** Withhold from gross taxable wages at the percentage checked (**check only one percentage**):
- 0.8%   
  1.3%   
  1.8%   
  2.7%   
  3.6%   
  4.2%   
  5.1%
- Check this box and enter an extra amount to be withheld from each paycheck ..... \$
- 2** I elect an Arizona withholding percentage of zero, and I certify that I expect to have no Arizona tax liability for the current taxable year.

I certify that I have made the election marked above.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**Employee's Instructions**

Arizona law requires your employer to withhold Arizona income tax from your wages for work done in Arizona. The amount withheld is applied to your Arizona income tax due when you file your tax return. The amount withheld is a percentage of your gross taxable wages from every paycheck. You may also have your employer withhold an extra amount from each paycheck. Complete this form to select a percentage and any extra amount to be withheld from each paycheck.

**What are my "Gross Taxable Wages"?**

For withholding purposes, your "gross taxable wages" are the wages that will generally be in box 1 of your federal Form W-2. It is your gross wages less any pretax deductions, such as your share of health insurance premiums.

**New Employees**

Complete this form within the first five days of your employment to select an Arizona withholding percentage. You may also have your employer withhold an extra amount from each paycheck. If you do not file this form, the department requires your employer to withhold 2.7% of your gross taxable wages.

**Current Employees**

If you want to change your current amount withheld, you must file this form to change the Arizona withholding percentage to change the extra amount withheld.

**What Should I do With Form A-4?**

Give your completed Form A-4 to your employer.

**Electing a Withholding Percentage of Zero**

You may elect an Arizona withholding percentage of zero if you expect to have no Arizona income tax liability for the current year. Arizona tax liability is gross tax liability less any tax credits, such as the family tax credit, school tax credits, or credits for taxes paid to other states. If you make this election, your employer will not withhold Arizona income tax from your wages for payroll periods beginning after the date you file the form. Zero withholding does not relieve you from paying Arizona income taxes that might be due at the time you file your Arizona income tax return. If you have an Arizona tax liability when you file your return or if at any time during the current year conditions change so that you expect to have a tax liability, you should promptly file a new Form A-4 and choose a withholding percentage that applies to you.

**Voluntary Withholding Election by Certain Nonresident Employees**

Compensation earned by nonresidents while physically working in Arizona for temporary periods is subject to Arizona income tax. However, under Arizona law, compensation paid to certain nonresident employees is not subject to Arizona income tax withholding. These nonresident employees need to review their situations and determine if they should elect to have Arizona income taxes withheld from their Arizona source compensation. Nonresident employees may request that their employer withhold Arizona income taxes by completing this form to elect Arizona income tax withholding.

# Form W-4 (2017)

**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.** If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

**Note:** If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

**Exceptions.** An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than \$1,000,000.

**Basic instructions.** If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

**Head of household.** Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

**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 may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

**Nonresident alien.** If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

**Future developments.** Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at [www.irs.gov/w4](http://www.irs.gov/w4).

## Personal Allowances Worksheet (Keep for your records.)

<b>A</b>	Enter "1" for <b>yourself</b> if no one else can claim you as a dependent . . . . .	<b>A</b> _____
<b>B</b>	Enter "1" if: { • You're single and have only one job; or • You're married, 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. } . . . . .	<b>B</b> _____
<b>C</b>	Enter "1" for your <b>spouse</b> . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . .	<b>C</b> _____
<b>D</b>	Enter number of <b>dependents</b> (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b> _____
<b>E</b>	Enter "1" if you will file as <b>head of household</b> on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b> _____
<b>F</b>	Enter "1" if you have at least \$2,000 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . . (Note: Do <b>not</b> include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	<b>F</b> _____
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then <b>less</b> "1" if you have two to four eligible children or <b>less</b> "2" if you have five or more eligible children. • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child.	<b>G</b> _____
<b>H</b>	Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ▶	<b>H</b> _____

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 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 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074 <b>2017</b>	
<b>1</b> Your first name and middle initial _____ Last name _____			<b>2</b> Your social security number _____		
Home address (number and street or rural route) _____			<b>3</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		
City or town, state, and ZIP code _____			<b>4</b> If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>		
<b>5</b> Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		<b>5</b> _____		<b>6</b> Additional amount, if any, you want withheld from each paycheck	
<b>6</b> _____		<b>6</b> \$ _____		<b>7</b> I claim exemption from withholding for 2017, and I certify that I meet <b>both</b> of the following conditions for exemption.	
• Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability, <b>and</b>		• This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability.		If you meet both conditions, write "Exempt" here . . . . . ▶ <b>7</b> _____	
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.					
<b>Employee's signature</b> (This form is not valid unless you sign it.) ▶ _____			<b>Date</b> ▶ _____		
<b>8</b> Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)			<b>9</b> Office code (optional)		<b>10</b> Employer identification number (EIN)