Employment Application			
Applicant Name:	DOB:	Gender:	SSN:
Address: (Street, City, State and Zip Code)			
Cell Phone Number:	Home Phone Number:	Email:	

Emergency Contact Information		
Name:	Relationship:	Phone Number:

Shift Availability		
☐ Full- Time ☐ Part Time ☐ Per Visit	☐ Day ☐ Nights ☐ Evening ☐ Weekend	**Position Applying:** _____ **Date Available:** _____ **Salary:** _____
List any other languages spoken other than English:		Do you have reliable transportation (including short notice during normal working hours):
Are you of legal age for the position in which you have applied for:		
Personal Reference Name:	Phone Number:	
Personal Reference Name:	Phone Number:	

Education History				
	Name	Location	Years Completed	Graduation Date
High School				
College				
Other				
Military Branch:		Date of Service:		Rank:

Licenses and Certifications			
License/Certification	ID Number	Expiration Date	State

Employment History		
Company Name:	Phone Number:	Supervisor:
Dates:	Position:	Reason for Leaving:
Company Name:	Phone Number:	Supervisor:
Dates:	Position:	Reason for Leaving:

Texas Angels Of Hope, LLC is an equal opportunity employer. All applicants and employees are considered for employment, advancement, and development based upon their skills, performance, and potential. No current or prospective employee will be discriminated against because of race, creed, color, gender, age, national origin, handicap, or military status

Reference Request

The individual listed has applied for a position with Texas Angels of Hope, LLC:

Name: _____ Social Security #: _____

Applicant's Authorization to Release Information

I hereby give permission for my previous employer to release this referral information about my position with their company and comments regarding my work ethic and character while in their employ.

Applicant's Signature: _____ **Date:** _____

THIS SECTION IS TO BE COMPLETED BY PREVIOUS EMPLOYER

Company Name: _____ **Phone Number:** _____

Address: _____ **Supervisor:** _____

Employment Dates: _____ Position: _____

Reason for separation: _____

Would you re-hire? _____ If not, why not? _____

Since this applicant has given your company as a former employer, we would consider it a favor both to the applicant and to us, if you would give us your opinion. We would greatly appreciate your answers to the following questions in the same way you would request us to complete a similar form for you.

EVALUATION	EXCELLENT	GOOD	AVERAGE	POOR
Attendance				
Quality of work				
Integrity				
Cooperation				
Dependability				
Appearance				
Stability				

Comments:

_____ _____

Signature/Title of Reference Date

Texas Angels Of Hope, LLC
6801 William Wallace Way, Austin TX 78754
(512) 614-4287 FAX: (512) 291-3414

** If reference is contacted by phone, agency staff will document & sign/date encounter on this page below

Reference Request

The individual listed has applied for a position with Texas Angels of Hope, LLC:

Name: _____ Social Security #: _____

Applicant's Authorization to Release Information

I hereby give permission for my previous employer to release this referral information about my position with their company and comments regarding my work ethic and character while in their employ.

Applicant's Signature: _____ **Date:** _____

THIS SECTION IS TO BE COMPLETED BY PREVIOUS EMPLOYER

Company Name: _____ **Phone Number:** _____

Address: _____ **Supervisor:** _____

Employment Dates: _____ Position: _____

Reason for separation: _____

Would you rehire? _____ If not, why not? _____

Since this applicant has given your company as a former employer, we would consider it a favor both to the applicant and to us, if you would give us your opinion. We would greatly appreciate your answers to the following questions in the same way you would request us to complete a similar form for you.

EVALUATION	EXCELLENT	GOOD	AVERAGE	POOR
Attendance				
Quality of work				
Integrity				
Cooperation				
Dependability				
Appearance				
Stability				

Comments:

_____ _____

Signature/Title of Reference Date

Texas Angels Of Hope, LLC
6801 William Wallace Way, Austin TX 78754
(512) 614-4287 FAX: (512) 291-3414

** If reference is contacted by phone, agency staff will document & sign/date encounter on this page below.

Job Description Acknowledgement	

Job Title: Personal Assistance Service Provider **Reports to: Designated Supervisor**

Job Summary: An unlicensed individual, who is under professional supervision, which provides assistance with ADL's and iADL's in the members' place of residence.

Qualifications:

- **AGE**: 18 years or older and has demonstrated competency. **If under the age of 18**, is a high school graduate or enrolled in a vocational educational program and has demonstrated competency to perform tasks assigned.
- **LICENSURE/CERTIFICATION:** Not required.
- **EDUCATION/TRAINING:** High school graduate/GED preferred.
- **EXPERIENCE:** Six months in home services setting.
- Not be the legal parent, foster parent, or spouse of a parent of a minor who receives services. Not the be the spouse of the individual receiving services, except for Family Care Services (FCS). Not be designated by the Case Manager as "Do Not Hire".

Health and Environmental Requirements: Must have negative results for TB and Hepatitis screenings. Must be able to lift, transfer and support the member if considered overweight or disabled. Must have the ability to stand for prolonged periods of time and perform motor skills such as stooping and bending. Must have reliable transportation, if driving a personal vehicle, employee must have valid driver's license and current automobile insurance and be able to travel locally. Must be proficient in writing, speaking, and understanding English.

Exposure Risk Category: Limited exposure to blood borne pathogens, infections, and bodily fluids, must use standard precautions provided in the Employee Handbook. Some exposure to unexpected weather and/or difficult scenarios involving interpersonal contact with members and members of the family. Must agree and pass all criminal background checks including Employee Misconduct Registry (EMR) and Nurse Aide Registry (NAR).

Responsibilities may include:

- Bathing (bed or shower) - Oral Hygiene - Assist with eating, dressing, and positioning – Basic Hair/Nail Care
- Medication Reminders - Routing Skin Care - Toileting – Meal preparation/Feeding – Linen Change/Laundry
- Light Housekeeping - Grocery Shopping - Companionship – Escorting and/or Transportation

Job Responsibilities and Functions:

- Follow universal precautions whenever giving any aspect of services to Member.
- Follow emergency procedures in case of any incident that may include accident, injury or changes involving members' condition.
- Follows Agency policy involving Client Rights and Responsibilities, Including HIPAA confidentiality.
- Provides authorized tasks to each member as assigned by schedule on Individualized Service Plan (ISP)
- Report any changes in condition of member or environment immediately to the assigned Supervisor.
- Follow all appropriate agency policies.
- Works assigned schedule, it is punctual and can follow instructions.
- Documents activities and submit documentation to the agency on a weekly basis (if applicable).
- Maintains positive communication and cooperation involving members, family members and coworkers.
- Other duties assigned by the Administrator/Supervisor when it is required by the Agency or members' needs.

Statement of Understanding: I have read the above Job Description and agree to perform these responsibilities as assigned, while maintaining member confidentiality according to HIPAA regulations. I understand the Job description does not constitute a contract of employment, and its changes may be made at any time. I acknowledge and understand that nothing in the job description may be construed as limiting Texas Angels of Hope, LLC right to initiate its Disciplinary policy for any unsatisfactory performance, or to exercise its rights at any time to terminate my employment.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

ACKNOWLEDGMENT OF SCHEDULE AND EVV POLICIES

I, _____, acknowledge that I have received, read, and fully understand the schedule provided to me by Texas Angels of Hope, LLC. I understand the following:

1. **Adherence to the Assigned Schedule**:
    - I understand that if I provide services outside of the assigned schedule without notifying the agency, I will not be compensated. The agency requires all employees not to work over the hours authorized each week. **Any hours worked over 40 weekly hours must be approved by the agency prior to compensation (Please refer to your employee handbook for additional information).**
2. **Communication of Schedule Changes**:
    - I understand that I am required to inform the agency of **ANY** schedule changes, including any requests made by the member.
    - Example scenarios include:
        - A member requests that I work any time other than what is scheduled.
        - If I miss time during the week and need to make it up, and the member agrees, I must contact the agency.
3. **Verification with Members**:
    - I understand that I must be present with the members when communicating with the agency, involving any schedule changes.
4. **Notification of EVV**:
    - I understand that the Office of Inspector General (OIG) monitors the accuracy of EVV verification procedures to detect any fraud, waste, or abuse involving Texas Medicaid programs.
    - I understand that failure to call in and/or out, as required by the EVV system, may result in corrective actions by the State.
    - I understand that I may be subject to fines, penalties, and termination of employment if found guilty by OIG, and any members found to be aware of schedule mismanagement may also face fraud charges, fines, and termination from Medicaid programs.
    - I understand that OIG can identify service providers who repeatedly fail to follow their schedules, specifically those who are off by 7 minutes or more.
5. **Compliance with Policies**:
    - I understand that I am required to follow my schedule as assigned and comply with all EVV policies as provided by Texas Angels of Hope, LLC.

By signing below, I acknowledge and agree to abide by the above policies and procedures.

Employee Name: _____ **Employee Signature:** _____ **Date:** _____

Agency Rep. Name: _____ **Agency Rep. Signature:** _____ **Date:** _____

Memorandum of Understanding

I attest that the information provided in this application is accurate, complete, and legitimate to the best of my ability. If I am hired and it is found that the information is inaccurate, incorrect, or illegitimate, I understand and agree that Texas Angels of Hope is relieved from all commitments including anything financial or pertinent to my employment, and that I am subject to immediate termination.

I understand that if I am an unlicensed individual having direct contact with members, Texas Angels of Hope will conduct a criminal background investigation including checks of the Nurse Aid Registry (NAR) and Employee Misconduct Registry (EMR) prior to my hire. Registry checks from NAR and EMR are to be completed annually if I am hired. If I have been convicted of a crime that forbids employment, I will not be hired. If at any time it is found I have any violations listed on NAR or EMR registries, I will not be hired.

I understand and acknowledge that Texas Angels of Hope will conduct checks of state and federal Office of Inspector General List of Excluded Individuals and Entities. These will be conducted each month once I am hired.
I understand and agree that Texas Angels of Hope will submit the Texas Employer New Hire Reporting Form to the Texas Attorney General's office, once I am hired.

I understand this application does not constitute a contract.

I understand and agree that if I am offered employment by Texas Angels of Hope, my employment will be at "will" for no definite period. Neither I nor the Agency will have the right to terminate employment relations at any time, with or without cause, and with or without notice. I understand that this status can only be changed by a written contract of employment that is specific to all materials terms and is signed by me and the Administrator, or designee of Texas Angels of Hope.

I understand that the State of Texas adopts the federal minimum wage of $7.25 per hour, effectively on July 24, 2009. (Texas Minimum Wage Act, Chapter 62 of the Texas Labor Code).

I understand and agree that Texas Health and Human Services (HHSC) will adopt the minimum wage of $10.60 per hour for personal attendants, effectively on September 1, 2023. (TAC Code Rule §355.7051)

Release of Information Consent

I authorize any previous employers to provide information requested regarding my employment with them.

I authorize the Registrar of all educational institutions I have attended to release official copies of my transcripts and if available, faculty appraisals.

I authorize any licensing board to release complete information about any licensing status and history I have acquired, if applicable.

Applicant Signature: _____ Date: _____

FOR OFFICE USE ONLY	☐Interview Completed	☐References Checked	If Hired: Position: Salary:	Start Date: FT/PT/Per Visit:

Completed By: _____ Date: _____

Service Provider Competency Checklist

Staff Name: **Date of Hire:** **Supervisor:**

Timeframe: ❑ **On hire** ❑ **Annual** ❑ **Review**

S= satisfactory U= unsatisfactory NA= not applicable	**Result**	**Date(s) & Observer Initials**	**Methodology OB/Verbal/ Demo**
BATHING			
Bed bath	S U NA		
Tub bath	S U NA		
Shower	S U NA		
Chair/sponge bath	S U NA		
NAIL CARE (no cutting)			
Fingernails	S U NA		
Toenails	S U NA		
SKIN CARE			
Shampoo	S U NA		
Lotion application	S U NA		
Shave (electric razor)	S U NA		
Incontinent care	S U NA		
ELIMINATION			
Assist to bathroom	S U NA		
Change drainage bag	S U NA		
ORAL CARE			
Brush teeth	S U NA		
Denture care	S U NA		
TRANSFERRING			
Chair to stand	S U NA		
Assist w/ ambulating	S U NA		
Bed to chair	S U NA		
HOUSEKEEPING TASKS			
Laundry	S U NA		
Change Bed linens	S U NA		
Cleaning/sanitizing	S U NA		
NUTRITION			
Meal prep	S U NA		
Feeding assist	S U NA		
Fluids encouraged/restricted	S U NA		
GENERAL			
Universal Precautions	S U NA		
Handwashing	S U NA		
Med Reminder/cueing with competent clients	S U NA		
Escorting Service (No Transport)	S U NA		
Bill paying	S U NA		

I attest that I am a qualified supervisor and have determined that the above candidate has successfully completed these skills.

Employee Printed Name: _____ Signature: _____ Date: _____

Supervisor Printed Name: _____Signature: _____ Date: _____

Tuberculosis Screening Questionnaire

Print Name_____

Early Detection of Tuberculosis: This questionnaire gives guidance in identifying individuals with suspected or confirmed TB so that appropriate controls can be promptly initiated.

AGENCY REP INSTRUCTIONS:

- Circle each answer provided by the employee and add your comments as the evaluator.
- Institute AMS exposure control measures outlined in AMS Exposure Control Plan, Respiratory Protection and Medical Surveillance Program and refer the individual for further evaluation if the individual has:
  (1) A persistent cough lasting 3 or more weeks and two or more symptoms of active TB.
  (2) Had a positive TB test on mucous that he/she coughed up.
  (3) Been told that he/she had TB and was treated, but never finished the medication.

TB HISTORY (Part 1)

1. Have you ever had a positive TB skin test? YES NO Don't Know
2. Have you ever had an abnormal chest x-ray? YES NO Don't Know
   If yes, how long ago?
3. Have you recently had the mucous you cough up tested for TB? YES NO Don't Know
   If yes, were you told it was positive?
4. Have you ever been told you have Infectious Tuberculosis? YES NO Don't Know
   If yes, how long ago?
5. Have you ever been treated with medication for Infectious TB? YES NO Don't Know
   If yes, how may medications? One Two Over Two
6. Are you still taking TB medicine? YES NO
   Did you take all the TB medicine until the health care professional told you that you were finished?
   Yes No
7. Do you live with, or have you been in close contact with someone who was recently diagnosed with TB? (ie. shelter roommate, close friend, relative). YES NO Don't Know

Employee Signature: **Date:**

CURRENT SYMPTOMS (Part Two, STAFF ONLY)

1. Do you have a cough that has lasted longer than three weeks? YES NO
2. Do you cough up blood or mucous? YES NO
3. Have you lost your appetite? Aren't hungry? YES NO
4. Have you lost weight (more than 10 pounds) in the last two months? Without trying to? YES NO
5. Do you have night sweats (need to change the sheets or your clothes because they are wet)? YES NO

Evaluator Comments:

Referred for Further Evaluation? YES NO

Evaluators Signature/Title: **Date:**

HEPATITIS B VACCINE ACCEPTANCE/DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious material, I may be at risk of acquiring the Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with the vaccine, at no charge to me. The series consists of 3 doses: an initial IM dose, a 2nd dose 30 days after and a 3rd dose at 6 months.
*PLEASE CHECK **ONE** OF THE FOLLOWING:*

☐ **I DECLINE HEPATITIS B SERIES:**

I DECLINE THAT VACCINATION AT THIS TIME.

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. 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. OSHA [56 FR 64004, Dec. 06, 1991, as amended at 57 FR 12717, April 13, 1992; 57 FR 29206, July 1, 1992; 61 FR 5507, Feb. 13, 1996]

Employee Signature **Date**

☐ **CONSENT TO HEPATITIS B VACCINE:**

I hereby consent to the administration of the Hepatitis B vaccine series and understand this will be at no charge to me. I know that I should not take this series if I am pregnant or nursing. I also understand that I should not take the vaccine if I have active infection present or have an allergy to the compound. I understand the risks and side effects of the injections and release the Agency from any liability that may arise from the effects of the vaccine.

BY SIGNING MY NAME BELOW, I AM STATING THAT I DO WISH TO HAVE THE HEPATITIS B VACCINE. I UNDERSTAND THAT THIS IS THREE (3) INJECTIONS AND THAT I MUST RECEIVE ALL INJECTIONS TO BE CONSIDERED VACCINATED AGAINST HBV INFECTION.
I AGREE TO FOLLOW THROUGH ON ALL 3 VACCINES.

_____

Employee Signature **Date**

Orientation for Service Providers

TOPICS COVERED	DATE AND INITIALS
Review of job duties	
Scheduling Guidelines	
Ethnic/Cultural Diversity/Ethics	
Conflict of Interest	
Client Rights & Responsibilities/TX Rights of the Elderly	
Reporting Client status changes/issues	
OSHA: Safe and appropriate use of equipment: HOME SAFETY: Bathroom safety Fire safety/Environmental safety/Electrical safety Adverse Events	_____ _____ _____ _____
Universal Precautions policy Handwashing policy	_____ _____
Exposure Control Plans Infection Control **Blood borne Pathogens** **TB**	_____ _____ _____ _____
Client Infection reporting	
Advance Directives	
Abuse: Screening & reporting (mandatory reporters) How to report	
Emergency preparedness: Employee role in disasters Disaster planning	 _____ _____
Do's and Don'ts of home services	
Competency skills testing (see skills checklist)	
Documentation	
Supervision & Performance Evaluation	
Staff Meetings	
Review Policies manuals Review and sign/date job description Review pays period, paydays and time sheets Approved reimbursement expenses Review policy for sick calls, call outs, bereavement benefits Performance evaluations Disciplinary action Ethics Policy/reporting issues Agency QA Program Other Committees	_____ _____ _____ _____ _____ _____ _____
Employee Printed Name/Title	Date
Employee Signature	
Trainer Printed Name/Title	Date
Trainer Signature	

Statement of Driving Status

Texas Angel of Hope, LLC

I, _____, am currently licensed to drive a motor vehicle in the state of Texas. I carry auto insurance on my vehicle, and I have supplied Texas Angels of Hope, LLC with a current copy of my license and auto insurance.

Employee Signature _____ Date: _____

OR:

NO CURRENT DRIVERS LICENSE

I, _____, declare that I do not have a driver's license in the state of TX and therefore will find other forms of transportation to get to my scheduled visits (i.e. public transportation)

Employee Signature _____ Date: _____

Equal Employment Opportunity (EEO) (100+ employees)

Qualified applicants are considered for employment without regard to race, religion, gender, national origin, age, marital status, veteran status, disability, or other protected characteristics. Furthermore, this employer is a government contractor and, as such, is committed to taking affirmative action to employ qualified females, minorities, disabled individuals, special disabled veterans, and veterans of the Vietnam era.

To help us comply with federal/state equal employment opportunity recordkeeping and reporting requirements, we request that you answer the following questions. **Completion of this form is <u>VOLUNTARY</u> on your part and will not preclude you from employment consideration. This detachable form will be kept in a confidential file separate from your application for employment.**

Name (Last, First, MI): _____
Street Address: _____
City, State, Zip Code: _____
Position Applied For: _____ Date Applied: _____

Gender Identification (check one) ____Female ____Male

Race/Ethnic Identification (check one)

_____ American Indian or Alaskan Native – All persons having origins in any of the original peoples of North America.

_____ Asian or Pacific Islander – All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands.

_____ Black (not of Hispanic origin) – All persons having origins in any of the Black racial groups of Africa.

_____ Hispanic – All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

_____ White (not of Hispanic origin) – All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Disability Identification (check if applicable)

Do you wish to identify yourself as an individual with a disabling condition and be considered under our Affirmative Action Plan? ____ Yes ____ No

Veteran Identification (check if applicable)

Do you wish to identify yourself as a Special Disabled Veteran or a Vietnam-era veteran and be considered under our Affirmative Action Plan? ____ Yes ____ No
Are you a "Special Disabled Veteran"? ____ Yes ____ No

Definition: "Special Disabled Veteran" means (i) a veteran of the U.S. military ground, naval, or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under the laws administered by the Department of Veterans Affairs for disability (A) rated at 30 percent or more, or (B) rated at 10 or 20 percent in the case of a veteran who has been determined under 38 U.S.C. 3106, to have a serious employment handicap; or (ii) a person who was discharged or released from active duty because of a service-connected disability.
Are you a Vietnam-era Veteran? ____ Yes ____ No

Definition: "Veteran of the Vietnam-era" means a person who served on active duty in the U.S. military ground, naval, or air service for a period of more than 180 days, and who was discharged or released there from with other than a dishonorable discharge, if any part of such duty was performed (A) in the Republic of Vietnam between February 28, 1961, and may 7, 1975, or (B) between August 5, 1964, through May 7, 1975, in all other cases.

Employee Signature _____ Date: _____

Texas Angels Of Hope, LLC

Conflict Of Interest

POLICY:
No employee or member of the Board of Directors or other individuals, committee, or entity shall derive any profit or gain directly or indirectly by reason of their association with the agency, without the prior knowledge and approval of the Board of Directors. All board members and/or employees, at the discretion and specific request of the board, will be required to submit a disclosure statement annually.
If a matter arises in which a member of the board or employee has a conflict of interest, it shall be promptly disclosed to the Administrator and Board of Directors.

In matters involving a conflict of interest, a board member must disclose any known significant reasons why a transaction might not be in the best interest of the agency and a board member shall not participate in discussions unless requested by the board nor vote on such transactions. The abstention and the reason for it shall be recorded in the minutes.

Field staff in any capacity understand that all Clients are Clients of the Agency not personal Clients of the staff. Clients may never be serviced privately by an employee of Our Agency for the financial gain of the employee. Should an employee terminate employment with Texas Angels of Hope, LLC, the field staff understand that the Client may not be encouraged or otherwise moved from our Agency to another agency.

INDIVIDUAL STATEMENT REGARDING CONFLICT OF INTEREST.

I, _____, have read and am fully familiar with the agency's policy statement regarding conflict of interest. I am not presently involved in any. transaction, investment, or other matters in which I would profit or gain directly or indirectly as a result of my membership of the agency's board of Directors or its committees or my employment.

Furthermore, I agree to disclose any such interest which may occur in accordance with the requirements of the policy and agree to abstain from any vote or action regarding the agency's business that might result in any profit or gain directly or indirectly, for myself.

I also work for another home services agency: Yes, _____ No _____

I am disclosing the name of the agency/agencies:

1._____

2._____

3._____

Employee Signature _____ Date: _____

Confidentiality Agreement

This agreement is made between _____ (the "Employee") and Texas Angels of Hope, LLC, (the "Employer") on the ___ of _____, 20____.

The Employee agrees to the terms of this Agreement:

1.) As a condition of employment, the employer requires that all new employees agree to enter into this Confidentiality Agreement (the Agreement). The Employee acknowledges that employment with an Employer is sufficient consideration for the Employee to enter into the Agreement.
2.) The Employee acknowledges that, in the course of employment, the Employee will, and may in the future, come into possession of certain confidential information belonging to the Employer including but not limited to trade secrets, data, products, products, technology, computer programs, specifications, manuals, business plans, software, marketing plans, financial information, and other information disclosed or submitted. This confidential information may be embodied in handwritten notes by the Employee, computer disks, tapes, paper, or any other media.
3.) The Employee hereby covenants and agrees that she or he will at no time, during or after the term of employment with the Employer, use for his or her own benefit or the benefit of others, or disclose or divulge to others, any such confidential information.
4.) Upon termination of employment, the Employee will return, retaining no copies or notes, all documents relating to the Employer's business including, but not limited to, reports, lists, correspondence, information, computer files, computer disks, and all other material and all copies of such material, obtained by the Employee during employment nor will the employee attempt to contact or solicit any Clients that the employee may have worked with during employment.
5.) The Employee recognizes that the Employer may be irreparably damaged by breach of this Agreement and that the Employer shall be entitled to seek an injunction to prevent such competition or disclosure, and will entitle the Employer to other legal remedies, including attorney's fees and costs.
6.) The obligations of the Recipient herein shall be effective from the date Owner last discloses any Confidential Information to Recipient pursuant to this Agreement.
7.) If any part of this Agreement is adjudged invalid, illegal, or unenforceable, the remaining parts shall not be affected and shall remain in full force and effect.
8.) This instrument, including any attached exhibits and addenda, constitutes the entire Agreement of the parties. No representation or promises have been made except those that are set out in this Agreement. This Agreement may not be modified except in writing signed by all parties.
9.) This agreement shall take effect as a sealed instrument and shall be construed, governed and enforced in accordance with the laws of the State of TX, without regard to its conflicts of law provisions.
10.) The descriptive headings used herein are for convenience of reference only and they are not intended to have any effect whatsoever in determining the rights or obligations under this agreement.

Employee Signature:_____ Title: _____ Date: _____

Employer Signature:_____ Title: _____ Date: _____

Acknowledgement of Infection Control Policy

Agency Statement

The Agency will employ infection control practices in the delivery of services to Agency clients, for the purpose of preventing the spread of infection within its client caseload to the highest degree.

Employee Acknowledgement

I acknowledge that I have received the Agency's infection control policy and procedures provided in the Employee Handbook.

I acknowledge that I have read and understood the infection control policy to its fullest capacity.

I understand that if exposed to bloodborne pathogens or potential infections, I am responsible for all treatment, testing, and follow-up. Furthermore, I understand that should I incur any injury or illness, I will also be responsible for all treatment and care resulting from such illness and/or injury.

I understand the following policy involving infection control in members of the Agency:

Infection Control in Staff and Clients:

a. Direct service staff are required to report any evidence of respiratory, dermatologic or other potentially communicable symptoms they discover when making a client visit the supervisor. Universal Precautions are strictly followed. Masks are required if respiratory symptoms are present.

b. Reported client infections are logged, tracked and reported to the QA Committee. Trends are identified and recommendations/action plans are formulated and implemented within the organization to improve the quality of the work environment.

I acknowledge that I have been educated on the following topics:

i. Universal precautions
ii. Handwashing and gloving
iii. Basic concepts of TB, Pandemic influenza including signs and symptoms
iv. Basic TB testing and explanation of importance
v. Direct service staff responsibilities
vi. Agency responsibility

I, _____, understand the above policy and procedures. I agree to follow the Agency's Infection Control and Bloodborne Pathogens policy and procedures.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

Acknowledgement of Policies and Procedures

Employee Sign Off Regarding HIPAA Privacy

I have read and understand this policy on Protected Health Information (PHI) and security. I understand that should any situation arise where I breach patient privacy I will be disciplined up to and including termination. I hereby agree to maintain patient confidentiality in the strictest manner possible, sharing or discussing patient information only with those designated care providers or supervisors who have "a need to know" and are actively involved in the care of services provided to the patients. I further acknowledge that I have been trained in the provisions and laws related to HIPAA compliance during orientation and those patients must sign written permission to allow their health information (PHI) to be disclosed. I further agree that I will protect PHI while servicing patients and will not allow any PHI to be visible.

Corporate Compliance Employee Sign Off

Our Agency is committed to providing the highest ethical health care and upholding conduct standards and corporate legal compliance. Our policies and Corporate Compliance Plan clearly support a 'zero' tolerance of any form of fraud or misconduct. This applies to all employees, direct and contracted, regardless of position or title. I, as an employee of the Agency, acknowledge that I have appraised and agree to comply with the Agency's Corporate Compliance Policy. I understand that in no way does this create an obligation or contract of employment and that I, as well as the Agency, have the right to end the employment relationship at any time.

Incident/Accidents Reporting Acknowledgement

I have been thoroughly informed by the Agency that I MUST report ALL incidents/accidents and any medical, physical, or mental changes involving the member, immediately to the Supervisor/office. I understand that in the event I become injured, even if I have a minor injury, I am required to report that incident to my office as soon as possible after an injury.

OUR AGENCY IS AVAILABLE BY PHONE 24 HOURS A DAY. THE ANSWERING SERVICE WILL RESPOND AFTER 5 PM WEEKDAYS AND ON WEEKENDS/HOLIDAYS.

Acknowledgement/Understanding of Zero Tolerance - Sexual Abuse Policy

I acknowledge that I have received and read the sexual abuse policy and/or have had it explained to me. I understand that the organization will not tolerate any employee, volunteer, board member or third party who commits sexual abuse. Disciplinary actions will be taken against those who are found to have committed sexual abuse. I understand that it is my responsibility to abide by all the rules contained in the policy. I also understand how to report incidents of sexual abuse as set forth in the abuse policy, including retaliating against any employee/volunteer exercising his or her rights under the policy.

Non-Discrimination/LEP Statement

I have reviewed & received information on the Agency Nondiscrimination LEP policy.

Acknowledgment and Understanding of Abuse, Neglect and Exploitation Policies

I acknowledge that I have received and understand the policies and procedures involving Abuse, Neglect and Exploitation Policies. I understand that the agency will not tolerate any employee, governing body, third party or client who commits any of these acts. I understand it is my responsibility to abide by the rules and report any incidents of abuse, neglect, and exploitation.

I acknowledge that I have received and read the Employee Handbook.

Acknowledgement of Agency Policy for Resignation and Terminations

I acknowledge that I have received information about the Agency's policy involving resignation and termination procedures.

Employee Signature: _____ **Date: _____**

Tuberculosis Training

The information provided serves as training involving Tuberculosis (TB). The following criteria are utilized to identify if an employee has the potential for TB.

Detection of employees who may have active TB is based on the following:

(Symptoms of TB disease depend on the area of the body where the bacteria is growing. TB disease in the lungs may cause symptoms such as:

i. Bad cough lasting 3 weeks or longer
ii. Pain in the chest; and/or
iii. Coughing up blood or sputum

Other symptoms of TB are:

iv. Weakness or fatigue
v. Weight loss
vi. No appetite
vii. Chills and/or fever
viii. Sweating at night

Groups with a higher prevalence of TB infection include:

ix. Medically underserved populations
x. Homeless individuals
xi. Alcoholics
xii. Current or past prison inmates
xiii. Injecting drug users
xiv. Elderly
xv. Foreign-born people from Asia, Caribbean and Latin America
xvi. Groups with greater risk to progress from latent TB infection to active disease
xvii. Contacts with individuals who have TB
xviii. Individuals with HIV infection, silicosis, after gastrectomy or jejuno-ileal bypass surgery, greater than 10 lbs. below normal body weight, chronic renal failure, diabetes, immunosuppressed due to medication
xix. Individuals who may have been infected within the past two years and individuals with fibrotic lung disease on a chest x-ray.

I have reviewed the signs and symptoms of Tuberculosis. I am not experiencing any signs and symptoms of TB currently. I understand if I experience any of these symptoms, I am to report to my supervisor or the Administrator immediately.

Employee Printed Name: _____Signature: _____ Date: _____

Agency Representative: _____Signature: _____ Date: _____

Name: _____ **Date:** _____ **Score:**_____

Bloodborne Pathogens/Hepatitis B

1. Bloodborne pathogens are transmitted through inhaling germs.

   TRUE FALSE

2. Bloodborne pathogens are microorganisms carried by human blood and other body fluids that can cause disease in humans.

   TRUE FALSE

3. Bloodborne pathogens may enter the body through open cuts and nicks.

   TRUE FALSE

4. Healthcare workers are more likely to be exposed to bloodborne pathogens.

   TRUE FALSE

5. You can get Hepatitis B by touching an infected person.

   TRUE FALSE

6. Where are bloodborne pathogens found?

A. Blood C. Hair

B. Body Fluids D. A & B

7. The most frequently transmitted bloodborne pathogen is

A. Hepatitis B C. Ebola Virus

B. Anthrax D. None of the above

8. A vaccine is available for

A. HIV C. Anthrax

B. Hepatitis D. Malaria

9. The most effective protection against the transmission of foodborne pathogens in the workplace is.

A. Isolation C. Wearing a mask

B. Proper hand washing D. None of the above

10. If you are exposed to body fluids in the workplace, you should

A. Wash the area thoroughly clean up if needed

B. Report on the incident to your supervisor

C. Contact appropriate personnel for

D. All the above

Name: _____ **Date:** _____ **Score:** _____ **Score:** _____

Emergency Preparedness Planning

1. **The agency should develop, maintain, and are prepared to implement their emergency preparedness plan if required.**

   a. True b. False

2. **The plan includes preparedness, mitigation, response and recovery.**

   a. True b. False

3. **An oil spill is considered a "disaster".**

   a. True b. False

4. **The agency must determine the level of emergency by conducting a risk assessment.**

   a. True b. False

5. **The plan includes specific responsibilities for the administrative, clinical, and non-clinical staff.**

   a. True b. False

Infection Control

1. Components of the chain of infections include:

   a. Susceptible host
   b. Entry portal
   c. Transmission of pathogen
   d. All the above

2. **Chemical hazards include patient medications.**

   a. True b. false

3. **You must do everything you can to prevent the spread of an infection.**

   a. True b. false

4. **If you wear gloves while providing care, hand hygiene is not required.**

   a. True b. False

Name: _____ **Date:** _____ **Score:** _____

HIPAA/CLIENT RIGHTS POST QUIZ

1. **What does the acronym HIPAA stand for?**

    a. Human Inclusion Practically Action
    b. Health Information Peace and plan
    c. Health Insurance Portability Accountability Act
    d. Healthful Inquiry Portability Action

2. **As a staff member who provides service to Agency clients, I am responsible for maintaining client confidentiality of services received and what happens within their home setting?**

    ____ TRUE ____ FALSE

3. **Who is responsible for understanding and following HIPAA rules?**

    a. Anyone who reads the newspaper
    b. Only cleaning staff
    c. All workers who visit the client on weekends
    d. Anyone who has contact with a client's personal health information

4. **What does "PHI" stand for?**

    a. Personal home ingredients
    b. Personal home guard history
    c. Protected health information
    d. Protection of home invasions

5. **What information is included in PHI?**

    a. The family members middle names
    b. Past vacation locations of the client
    c. Clothing sizes of the client
    d. Social security number, age, date of birth

6. **What information can be disclosed <u>without</u> specific consent of the Client?**

    a. Nothing
    b. Specific information required for client treatment, payment or legal issues
    c. Information about shopping
    d. Information on the grocery menu

7. **Can service be provided prior to obtaining Client's signature on consent form?**

    a. Yes
    b. No
    c. Sometimes
    d. Only on Sundays

8. **Out of 18 possible personal identifiers, how many must be removed when de-identifying PHI?**

    a. All that mentions the client's food preferences
    b. 21
    c. All 18 of them
    d. Family names of cousins

9. **I can talk with a client about the care/services received by another client"**

    ____ True _____ False

10. **If I feel confidentiality has been breached, I should:**

    a. Open all the windows in the client's home
    b. Be sure to call my gardener
    c. Tell the next delivery man who comes to the house
    d. Contact my supervisor immediately

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____ , acknowledge that a Computerized Criminal

APPLICANT or EMPLOYEE NAME (Please print)

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

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

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

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

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

_____
Signature of Applicant or Employee (optional)

_____
Date

Texas Angels of Hope LLC
Agency Name (Please print)

Janet M. Moreno
Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES _____ NO _____ JM initial

Purpose of CCH: EMPLOYMENT

Empl ___ Vol/Contractor ___ JM initial

Date Printed:_____ JM initial

Destroyed Date:_____ _____ initial

Retain in your files

Rev. 09/2015

DP0002 10/23
Form Expires 10/31/27

PAYCHEX, INC.

Direct Deposit Enrollment / Change Form*

Note: Digital or Electronic Signatures are not acceptable

Company Name and/or Client Number Texas Angels of Hope, LLC

Employee/Worker Name_____**Employee/Worker Number**_____
(Print Legible First and Last Name)

Employer/Employee: Retain a copy of this form your records

COMPLETE TO ENROLL / ADD / CHANGE BANK ACCOUNTS - *PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY*																	
Add new account	**Update existing account**	**Replace existing (Account # being replaced)**															
Type of Account: **Checking** **Savings**																	
Account Holder's Name:																	
If a Trustee or Custodial for a Minor, please list complete title of account. (Example: John Doe Custodian for Minor Jane Doe)																	
Routing/Transit Number																	
Account Number **																	
Financial Institution ("Bank") Name:																	
Deposit of Pay (select one):			**% of net**			**Specific dollar amount $**			**.00**			**Remainder of Net**					

Add new account	**Update existing account**	**Replace existing account**															
Type of Account: **Checking** **Savings**																	
Account Holder's Name:																	
If a Trustee or Custodial for a Minor, please list complete title of account. (Example: John Doe Custodian for Minor Jane Doe)																	
Routing/Transit Number																	
Account Number **																	
Financial Institution ("Bank") Name:																	
Deposit of Pay (select one):			**% of net**			**Specific dollar amount $**			**.00**			**Remainder of Net**					

Add new account	**Update existing account**	**Replace existing account**															
Type of Account: **Checking** **Savings**																	
Account Holder's Name:																	
If a Trustee or Custodial for a Minor, please list complete title of account. (Example: John Doe Custodian for Minor Jane Doe)																	
Routing/Transit Number																	
Account Number **																	
Financial Institution ("Bank") Name:																	
Deposit of Pay (select one):			**% of net**			**Specific dollar amount $**			**.00**			**Remainder of Net**					

CONFIRMATION STATEMENT - ***PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY***

I authorize my employer/company to deposit my earnings into the bank account(s) specified above, and, if necessary, to electronically debit my account to correct erroneous entries. I certify my account(s) allow these transactions. Furthermore, I certify that the above listed account number accurately reflects my intended receiving account. I agree that direct deposit transactions I authorize comply with all applicable laws. My signature below indicates that I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer/company make direct deposits into the named account. I understand that this authorization will remain in full force and effect until I notify Company in writing that I wish to revoke my authorization. I understand that the Company requires at least 5 business days prior notice to cancel this authorization.

Employee/Worker Signature: **Date:** **(MM/DD/YY)**

I confirm that the above named employee/worker has added or changed a bank account for direct deposit transactions processed by Paychex, Inc. I have reviewed the information provided and it is accurate to the best of my knowledge. My signature below indicates that I have the authority to execute this document on behalf of the Client.

Employer/Authorized Company Representative Printed Name: Janet M. Moreno

Employer/Authorized Company Representative Signature: Janet M. Moreno **Date:** **(MM/DD/YY)**

*** All fields are required except Employee/Worker Number.**

**** Certain accounts may have restrictions on deposits and withdrawals. Verify with your bank for more information specific to your account.**

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

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

Future Developments

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

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

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

2. Expect to work only part of the year;

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

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

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

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

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

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

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

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

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

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

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

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

1 Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

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

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Texas Angels of Hope, LLC	**6801 William Wallace Way, Austin, Texas 78754**

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

LISTS OF ACCEPTABLE DOCUMENTS

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

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

Acceptable Receipts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B,
Reverification and Rehire (formerly Section 3)

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

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

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

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

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

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

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

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

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

Additional Information (Initial and date each notation.)

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

MISCONDUCT/NURSE AIDE REGISTRY INFORMATION FOR EMPLOYEES

The purpose of the Nurse Aide Registry and Employee Misconduct Registry are to ensure that unlicensed personnel who commit acts of abuse, neglect or misconduct towards members and consumers are denied employment in DADS or HHSC related agencies and facilities.

As part of HHSC and DADS, we are required to check the EMR/NAR before your hire and on an annual basis. These registry checks are required to determine if an individual has committed the following:

- Abuse
- Exploitation
- Misappropriation
- Misconduct
- Neglect

I, _____, acknowledge that I have read and
(print name)

understand the stated information above involving the Employee Misconduct Registry and Nurse Aide Registry. I understand that I am unemployable in any DADS/HHSC regulated agencies if I am found listen on the EMR and NAR registry, as having committed any of the violations against a member or consumer.

Employee Signature: _____ Date: _____

Statement Of Employability

By execution of this document, I acknowledge that I have been informed by Texas Angels of Hope, LLC and agree that Texas Angels of Hope, LLC will conduct a State of Texas criminal history check, search the Nurse Aide Registry (NAR), and search the Employee Misconduct Registry (EMR) per the Texas Administrative Code §93.3, Chapter 250 of the Health and Safety Code, Nurse Aid Registry and Criminal History Checks of Employees and Applicants for Employment in Certain Facilities Serving the Elderly, Persons with Disabilities, Persons with Terminal Illnesses, and Chapter 253, of the Texas Health and Safety Code, Employee Misconduct Registry, or if listed as unemployable in the Office of the Inspector Generals List of Excluded Individuals and Entities (LEIE) pursuant to sections 1128 and 1156 of Social Security Act. I understand that I am not employable if I am listed in the Employee Misconduct Registry or if I have a criminal conviction or offense that bars me from employment with this Agency. I have been informed that the Agency will also conduct a search of the NAR and the EMR on an annual basis.

Background Checks
I have informed this agency of all names (i.e., maiden, aliases) that I have used in the past. I understand that my employment is pending the results of the Criminal History Check, and verification on the Nurse Aide Registry and the Employee Misconduct Registry. I understand that I may not have patient contact until all results are concluded.

CONVICTIONS BARRING EMPLOYMENT Health and Safety Code §250.006
A. A person for whom the facility is entitled to obtain criminal history record information may not be employed in a facility if the person has been convicted of an offense listed below: • An offense under Chapter 19, Penal Code (criminal homicide);

- An offense under Chapter 20, Penal Code (kidnapping, unlawful restraint, and smuggling of persons);
- An offense under Chapter 21.02, Penal Code (continuous sexual abuse of young child or children);
- An offense under Section 21.08, Penal Code (indecent exposure);
- An offense under Section 21.12, Penal Code (improper relationship between educator and student);
- An offense under Section 21.15, Penal Code (improper photography or visual recording);
- An offense under Section 22.011, Penal Code (sexual assault);
- An offense under Section 22.02, Penal Code (aggravated assault);
- An offense under Section 22.021, Penal Code (aggravated sexual assault) ;
- An offense under Section 22.04, Penal Code (injury to a child, elderly individual, or disabled individual);
- An offense under Section 22.041, Penal Code (abandoning or endangering a child);
- An offense under Section 22.05, Penal Code (deadly conduct);
- An offense under Section 22.07, Penal Code (terroristic threat);
- An offense under Section 22.08, Penal Code (aiding suicide);
- An offense under Section 25.031, Penal Code (agreement to abduct from custody);
- An offense under Section 25.08, Penal Code (sale or purchase of a child);
- An offense under Section 28.02, Penal Code (arson);
- An offense under Section 29.02, Penal Code (robbery);
- An offense under Section 29.03, Penal Code (aggravated robbery);
- An offense under Section 32.53, Penal Code (exploitation of child, elderly individual, or disabled individual);
- An offense under Section 33.021, Penal Code (online solicitation of a minor);
- An offense under Section 34.02, Penal Code (money laundering);
- An offense under Section 35A.02, Penal Code (Medicaid fraud);
- An offense under Section 36.06, Penal Code (obstruction or retaliation);
- An offense under Section 42.09, Penal Code (cruelty to livestock animals);
- An offense under Section 42.092, Penal Code (cruelty to no livestock animals);
- A conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed by this subsection; or
- An offense the Agency determines to be contraindicated to employment with the consumers the Agency serves.

B. A person may not be employed in a position in which the duties involve direct contact with a patient in a facility before the fifth anniversary of the date the person is convicted of:

- An offense under Section 22.01, Penal Code (assault punishable as a Class A misdemeanor or felony);
- An offense under Section 30.02, Penal Code (burglary);
- An offense under Chapter 31, Penal Code (theft punishable as a felony);
- An offense under Section 32.45, Penal Code (misapplication of fiduciary property or property of a financial institution punishable as a Class A misdemeanor or felony);

- An offense under Section 32.46, Penal Code (securing execution of a document by deception punishable as a Class A misdemeanor or felony);
- An offense under Section 37.12, Penal Code (false identification as a peace officer); misrepresentation of property; or
- An offense under Section 42.01(a)(7), (8), or (9), Penal Code (disorderly conduct).

C. In addition to the prohibitions on employment prescribed by Subsections (A) and (B), a person for whom a facility licensed under Chapter 242 or 247 is entitled to obtain criminal history record information may not be employed in a facility licensed under Chapter 242 or 247 if the person has been convicted:

- Of an offense under Section 30.02, Penal Code (burglary); or
- Under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense under Section 30.02, Penal Code.

D. In addition to the prohibitions prescribed by Subsections (A), (B) and (C), a nurse aide who is designated in the NAR or the EMR with a finding concerning abuse, neglect, or exploitation or mistreatment of a patient of an agency or a facility, or misappropriation of a patient's property is not employable.

E. I understand that if I have been placed on deferred adjudication community supervision for an offense listed in the section above, and successfully complete the period of deferred adjudication community supervision and receive a dismissal and discharge in accordance with Article 42A.111, Code of Criminal Procedure, I am not considered convicted of the offense.

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may bar my employment. I understand that all information obtained by this agency regarding any criminal history will remain confidential.
I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

_____

Signature of Applicant/Unlicensed Contractor/Employee **Date**

FOR AGENCY USE ONLY:

Texas and Safety Code §253.008. Verification of Employability: Employee Misconduct Registry (EMR); Nurse Aide Registry (NAR)

☐ **EMR/NAR checked by using DADS' Employability Status Search website at:**
https://emr.dads.state.tx.us/DadsEMRWeb/

☐ **Criminal History check completed by one of the following methods: Electronically, disk or typewritten form submitted to the Department of Public Safety for unlicensed applicant/employee with face-to-face contact with member.**

☐ Applicant / employee has no offense(s) and **is employable.**
☐ Applicant/employee has offense(s) which bar employment and **is not employable.**

Verified By: _____ Date: _____