

DSP Rate Setting Tool

Name _____ Date _____

_____ Base Start Rate: (DSP) \$13.25

_____ Base Start Rate: (SHF, Westbrook, Preble) \$14.25

_____ Base Start Rate: (Floater) \$15.25

Check category of new hire position: _____ HPC _____ ADS/DH _____ Both

Sign-On Bonus

Required Certifications and/or Trainings

(Paid after 6 months of employment. Not eligible if a CICL rehire and training was previously provided by CICL)

_____ CPR and FA (\$50 each for a maximum of \$100) \$ _____

_____ Delegated Nursing / Medication Administration \$200

_____ STNA / CNA \$200

_____ Post High School degrees or advanced certifications \$250

_____ PATHS Certification _____ CIP \$250

_____ CAP \$500

Starting Rate Adjustments: Experience in the Field

(Related experience in elder care, DD, nursing home, assisted living, HHA)

_____ 1 year-3 years: \$.050/hr

_____ 3 years to 10 years: \$0.75/hr

_____ 10 years or more experience \$1.00/hr

Non-Driving DSP's starting rate is reduced by \$0.50/hour _____

Non-Medication Administration Certification starting rate is reduced by \$0.50/hour _____

STARTING RATE will be: _____

Weekend rate adjustment: \$1.00 extra/hour

Competency Add On: (requires 4160 hours of DSP experience plus 60 additional hours of training) \$1.00/hour

\$100 gift card sign on bonus: Upon completion of in house training and location shadow training

Human Resources Approved _____ Date _____

PAYROLL AUTHORIZATION FOR NEW EMPLOYEE



EMPLOYEE DATA

DATA ENTRY /CHECKS

SS #		Paycor #:
Last Name:		
First Name / Middle:		Provide Entered:
Street Address:		
City:		Compliance Entered:
State:		
County:		
Zip:		Physical Scheduled:
Gender:		Physical Date/Time:
Status:		
Area Code/Phone #:		
Home Department:		Excluded Person/Entities:
Position Title:		Abuser Registry:
Supervisor:		Nurse Aid Registry:
Date Control (FT/PT):		Sex/Child Offender Database:
Pay Rate / Hour:		Serv. Admin System Award Mgmt. Database:
EEO-Race:		DB of Incarcerated/Supervised
Marital Status:		
Federal Exemptions:		NOTES/NEEDED:
State Exemptions:		
Hire/Orientation Date:		
Birth Date:		
CPR Certified through:		
First Aid Certification through:		
FLSA:		
Regular Temporary:	REGULAR	
Scheduled Hours:		
# of 24 hour shifts:		
Direct Deposit Routing #:		REPORTED NEW HIRE:
Direct Deposit Account #:		REPORTED TO RAPBACK:
Driver's License State & Driver's License Issue Date:		
Driver's License Expiration		
E-Mail Address:		
Approved By:		
Processing Date:		

Processing Date: _____

Processing Time: _____

You will be meeting with: _____

Please bring:

- *Valid Driver's License
- *Social Security Card
- *HS or College Diploma, GED, or Transcripts
- *Proof of Car Insurance
- *Bank Account Info (Acct and Routing Number)
Voided Check, or Direct Deposit Form

There will be no exceptions. Your information will not be processed until we have all the above information.

If you have your CPR/FA card, or delegated nursing, please also bring this to the day of your processing.

BCI Completion Receipt

- BCI**
- FBI**

To be completed by Authorized Representative:

(Employee Name) _____, completed his/her BCI/FBI report on ____
/ ____ / ____ at (Location) _____.

Mailed BCI results are to be sent directly to 1651 Needmore Rd. Dayton, OH 45414. All other BCI's can be scanned directly to Mwelch@cicloh.com or faxed to 937-898-3553. For any questions you can contact us directly at 937-898-2220

Authorized Representative Signature: _____

Authorized Representative Print Name: _____

Contact Information: _____

(If applicable) Authentication Number: _____

To be completed by HR Representative:

Rapback needs to be reported by: ____ / ____ / ____

Enrolled into Rapback on: ____ / ____ / ____

BCI results need to be received by: ____ / ____ / ____

BCI results were received on: ____ / ____ / ____

***We have 30 days from day of fingerprinting to report the individual to Rapback. We have 60 days to receive the BCI results. If we do not receive the individuals BCI within the 60-day criteria, the employee will need to be pulled from their current working schedule until we have received the BCI report. ***

Hepatitis B Information Sheet

Choices in Community Living
1651 Needmore Road
Dayton, OH 45414
Phone: 937-898-2220 Fax: 937-898-3553

Employee Name _____

Hepatitis B is a very serious and potentially deadly disease. It is a virus, one of two blood borne pathogens (along with HIV) that are contracted through exposure to infected blood and various body fluids/secretions. Choices in Community Living offers Hepatitis B vaccinations to you, free of charge. In fact, this vaccination is part of OSHA's Workplace Safety Program as it relates to blood borne pathogens and universal precautions. As such, Choices in Community Living must offer you this vaccination and most thoroughly document your decision. You must declare one of the following three statements:

- I agree to take the vaccination (a series of three shots over a six month period) and will schedule time to do so
- I was previously vaccinated (prior to employment with this agency) and will turn in proof of the vaccination for your records
- I decline the vaccination I understand that by declining, 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 and other potentially infectious materials and I want to be vaccinated. I can receive the vaccination series at no charge to me.

Employee Signatures

Date

Description of the process

Hepatitis B vaccine is comprised of three separate stages: after the first shot, you must wait 30 days before receiving the second shot. You will receive third and final shot five months following your second shot. While this series of shot results in "permanent" inoculation. Authorities generally recommend boosters after five to ten years

Authorization

This form authorizes this employee to receive the hepatitis B series from Montgomery County Combines Health District and Choices in Community Living agrees to pay for the cost of the shots.

Human Resource Representative

Date

Choices in Community Living, Inc.

Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize Choices in Community Living, Inc. to initiate automatic deposits to my account at the financial institution named below. I also authorize Choices in Community, Inc. to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Choices in Community Living, Inc. responsible for any delay of funds due to incorrect or incomplete information supplied by me or my financial institution or due to an error on the part of financial institution in depositing funds to my account.

This agreement will remain in effect until Choices in Community Living, Inc. receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Account Information

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ Circle One: **Checking / Savings**

Are you currently set-up for Direct Deposit? If yes, go to the next question Yes ___ No ___

Should the current account be removed from your payroll file? Yes ___ No ___

If no, How much do you want deposited into the new account? \$ _____

Signature

Authorized Signature (Primary): _____ Date: _____

Authorized Signature (Joint): _____ Date: _____

Please attach a voided check or deposit slip and return this form to the Payroll Department



Instructions

Start Over

Print

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

▶ START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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.)

Form fields for Section 1: Last Name (Family Name), First Name (Given Name), Middle Initial, Other Last Names Used (if any), Address (Street Number and Name), Apt. Number, City or Town, State, ZIP Code, Date of Birth (mm/dd/yyyy), U.S. Social Security Number, Employee's E-mail Address, Employee's Telephone Number.

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

Attestation options: 1. A citizen of the United States, 2. A noncitizen national of the United States, 3. A lawful permanent resident, 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy). Includes document number fields and QR code area.

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

Preparer and/or Translator Certification (check one): I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1. (Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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, Today's Date (mm/dd/yyyy), Last Name (Family Name), First Name (Given Name), Address (Street Number and Name), City or Town, State, ZIP Code.

Click to Finish





Instructions

Start Over

Print

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification
(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1
Last Name (Family Name)
First Name (Given Name)
M.I.
Citizenship/Immigration Status

List A Identity and Employment Authorization OR List B Identity AND List C Employment Authorization
Document Title, Issuing Authority, Document Number, Expiration Date
Additional Information
QR Code - Sections 2 & 3 Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment (mm/dd/yyyy): (See instructions for exemptions)

Signature of Employer or Authorized Representative
Today's Date (mm/dd/yyyy)
Title of Employer or Authorized Representative
Last Name of Employer or Authorized Representative
First Name of Employer or Authorized Representative
Employer's Business or Organization Name
Employer's Business or Organization Address (Street Number and Name)
City or Town
State
ZIP Code

Click to Finish



Instructions

Start Over

Print

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Employee Name from Section 1:	Last Name (Family Name) ?	First Name (Given Name) ?	Middle Initial ?
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Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable) ?			B. Date of Rehire (if applicable)
Last Name (Family Name) ?	First Name (Given Name) ?	Middle Initial ?	Date (mm/dd/yyyy) ?

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title ?	Document Number ?	Expiration Date (if any) (mm/dd/yyyy) ?
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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 document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative ?	Today's Date (mm/dd/yyyy) ?	Name of Employer or Authorized Representative ?
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Click to Finish

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

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
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status 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. 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 	OR	<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

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.**

2021

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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

Step 2: 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.

Multiple Jobs or Spouse Works Do only one of the following.

(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); or

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; 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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld..... ▶

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents	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 and 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)
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General Instructions

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 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 **and** you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), 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 2021 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2022.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

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

If you (and your spouse) have a total of only two jobs, you may instead 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 roughly 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. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. 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 2021 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.

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 2021 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: { • \$25,100 if you're married filing jointly or qualifying widow(er) • \$18,800 if you're head of household • \$12,550 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 possessions 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 Widow(er)

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	\$190	\$850	\$890	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,100	\$1,870	\$1,870
\$10,000 - 19,999	190	1,190	1,890	2,090	2,220	2,220	2,220	2,220	2,300	3,300	4,070	4,070
\$20,000 - 29,999	850	1,890	2,750	2,950	3,080	3,080	3,080	3,160	4,160	5,160	5,930	5,930
\$30,000 - 39,999	890	2,090	2,950	3,150	3,280	3,280	3,360	4,360	5,360	6,360	7,130	7,130
\$40,000 - 49,999	1,020	2,220	3,080	3,280	3,410	3,490	4,490	5,490	6,490	7,490	8,260	8,260
\$50,000 - 59,999	1,020	2,220	3,080	3,280	3,490	4,490	5,490	6,490	7,490	8,490	9,260	9,260
\$60,000 - 69,999	1,020	2,220	3,080	3,360	4,490	5,490	6,490	7,490	8,490	9,490	10,260	10,260
\$70,000 - 79,999	1,020	2,220	3,160	4,360	5,490	6,490	7,490	8,490	9,490	10,490	11,260	11,260
\$80,000 - 99,999	1,020	3,150	5,010	6,210	7,340	8,340	9,340	10,340	11,340	12,340	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,930	7,130	8,260	9,320	10,520	11,720	12,920	14,120	15,090	15,290
\$150,000 - 239,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,230	16,190	16,400
\$240,000 - 259,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,270	17,040	18,040
\$260,000 - 279,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,870	14,870	16,870	18,640	19,640
\$280,000 - 299,999	2,040	4,440	6,500	7,900	9,230	10,470	12,470	14,470	16,470	18,470	20,240	21,240
\$300,000 - 319,999	2,040	4,440	6,500	7,940	10,070	12,070	14,070	16,070	18,070	20,070	21,840	22,840
\$320,000 - 364,999	2,720	5,920	8,780	10,980	13,110	15,110	17,110	19,110	21,190	23,490	25,560	26,860
\$365,000 - 524,999	2,970	6,470	9,630	12,130	14,560	16,860	19,160	21,460	23,760	26,060	28,130	29,430
\$525,000 and over	3,140	6,840	10,200	12,900	15,530	18,030	20,530	23,030	25,530	28,030	30,300	31,800

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	\$440	\$940	\$1,020	\$1,020	\$1,410	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040	\$2,040
\$10,000 - 19,999	940	1,540	1,620	2,020	3,020	3,470	3,470	3,470	3,640	3,840	3,840	3,840
\$20,000 - 29,999	1,020	1,620	2,100	3,100	4,100	4,550	4,550	4,720	4,920	5,120	5,120	5,120
\$30,000 - 39,999	1,020	2,020	3,100	4,100	5,100	5,550	5,720	5,920	6,120	6,320	6,320	6,320
\$40,000 - 59,999	1,870	3,470	4,550	5,550	6,690	7,340	7,540	7,740	7,940	8,140	8,150	8,150
\$60,000 - 79,999	1,870	3,470	4,690	5,890	7,090	7,740	7,940	8,140	8,340	8,540	9,190	9,990
\$80,000 - 99,999	2,000	3,810	5,090	6,290	7,490	8,140	8,340	8,540	9,390	10,390	11,190	11,990
\$100,000 - 124,999	2,040	3,840	5,120	6,320	7,520	8,360	9,360	10,360	11,360	12,360	13,410	14,510
\$125,000 - 149,999	2,040	3,840	5,120	6,910	8,910	10,360	11,360	12,450	13,750	15,050	16,160	17,260
\$150,000 - 174,999	2,220	4,830	6,910	8,910	10,910	12,600	13,900	15,200	16,500	17,800	18,910	20,010
\$175,000 - 199,999	2,720	5,320	7,490	9,790	12,090	13,850	15,150	16,450	17,750	19,050	20,150	21,250
\$200,000 - 249,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
\$250,000 - 399,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
\$400,000 - 449,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,910	21,220	22,520
\$450,000 and over	3,140	6,250	8,830	11,330	13,830	15,790	17,290	18,790	20,290	21,790	23,100	24,400

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	\$820	\$930	\$1,020	\$1,020	\$1,020	\$1,420	\$1,870	\$1,870	\$1,910	\$2,040	\$2,040
\$10,000 - 19,999	820	1,900	2,130	2,220	2,220	2,620	3,620	4,070	4,110	4,310	4,440	4,440
\$20,000 - 29,999	930	2,130	2,360	2,450	2,850	3,850	4,850	5,340	5,540	5,740	5,870	5,870
\$30,000 - 39,999	1,020	2,220	2,450	2,940	3,940	4,940	5,980	6,630	6,830	7,030	7,160	7,160
\$40,000 - 59,999	1,020	2,470	3,700	4,790	5,800	7,000	8,200	8,850	9,050	9,250	9,380	9,380
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,850	11,050	11,250	11,520	12,320
\$80,000 - 99,999	1,880	4,280	5,710	7,000	8,200	9,400	10,600	11,250	11,590	12,590	13,520	14,320
\$100,000 - 124,999	2,040	4,440	5,870	7,160	8,360	9,560	11,240	12,690	13,690	14,690	15,670	16,770
\$125,000 - 149,999	2,040	4,440	5,870	7,240	9,240	11,240	13,240	14,690	15,890	17,190	18,420	19,520
\$150,000 - 174,999	2,040	4,920	7,150	9,240	11,240	13,290	15,590	17,340	18,640	19,940	21,170	22,270
\$175,000 - 199,999	2,720	5,920	8,150	10,440	12,740	15,040	17,340	19,090	20,390	21,690	22,920	24,020
\$200,000 - 249,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
\$250,000 - 349,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
\$350,000 - 449,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,900	25,200
\$450,000 and over	3,140	6,840	9,570	12,160	14,660	17,160	19,660	21,610	23,110	24,610	26,050	27,350



Employee's Withholding Exemption Certificate

Submit form IT 4 to your employer on or before the start date of employment so your employer will withhold and remit Ohio income tax from your compensation. If applicable, your employer will also withhold school district income tax. You must file an updated IT 4 when any of the information listed below changes (including your marital status or number of dependents). You should contact your employer for instructions on how to complete an updated IT 4. Your employer may require you to complete this form electronically.

Section I: Personal Information

Form with fields for Employee Name, Employee SSN, Address, city, state, ZIP code, School district of residence, and School district number.

Section II: Claiming Withholding Exemptions

- 1. Enter "0" if you are a dependent on another individual's Ohio return; otherwise enter "1"
2. Enter "0" if single or if your spouse files a separate Ohio return; otherwise enter "1"
3. Number of dependents
4. Total withholding exemptions (sum of line 1, 2, and 3)
5. Additional Ohio income tax withholding per pay period (optional)

Section III: Withholding Waiver

I am not subject to Ohio or school district income tax withholding because (check all that apply):

- I am a full-year resident of Indiana, Kentucky, Michigan, Pennsylvania, or West Virginia.
I am a resident military servicemember who is stationed outside Ohio on active duty military orders.
I am a nonresident military servicemember who is stationed in Ohio due to military orders.
I am a nonresident civilian spouse of a military servicemember and I am present in Ohio solely due to my spouse's military orders.
I am exempt from Ohio withholding under R.C. 5747.06(A)(1) through (6).

Section IV: Signature (required)

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

Signature Date

IT 4 Instructions

Most individuals are subject to Ohio income tax on their wages, salaries, or other compensation. To ensure this tax is paid, employers maintaining an office or transacting business in Ohio must withhold Ohio income tax, and school district income tax if applicable, from each individual who is an employee.

Such employees who are subject to Ohio income tax (and school district income tax, if applicable) should complete sections I, II, and IV of the IT 4 to have their employer withhold the appropriate Ohio taxes from their compensation. If the employee does not complete the IT 4 and return it to his/her employer, the employer:

- Will withhold Ohio tax based on the employee claiming **zero exemptions**, and
- **Will not** withhold school district income tax, even if the employee lives in a taxing school district.

An individual may be subject to an interest penalty for underpayment of estimated taxes (on form IT/SD 2210) based on under-withholding.

Certain employees may be **exempt** from Ohio withholding because their income is not subject to Ohio tax. Such employees should complete sections I, III, and IV of the IT 4 **only**.

The IT 4 does not need to be filed with the Department of Taxation. Your employer must maintain a copy as part of its records.

R.C. 5747.06(A) and Ohio Adm.Code 5703-7-10.

Section I

Enter the four-digit school district number of your primary address. If you do not know your school district of residence or its school district number, use *The Finder* at tax.ohio.gov. You can also verify your school district by contacting your county auditor or county board of elections.

If you move during the tax year, complete an updated IT 4 immediately reflecting your new address and/ or school district of residence.

Section II

Line 1: If you can be claimed on someone else's Ohio income tax return as a dependent, then you are to enter "0" on this line. Everyone else may enter "1".

Line 2: If you are single, enter "0" on this line. If you are married and you and your spouse file separate Ohio Income tax returns as "Married filing Separately" then enter "0" on this line.

Line 3: You are allowed one exemption for each dependent. Your dependents for Ohio income tax purposes are the same as your dependents for federal income tax purposes. See R.C. 5747.01(O).

Line 5: If you expect to owe more Ohio income tax than the amount withheld from your compensation, you can request that your employer withhold an additional amount of Ohio income tax. This amount should be reported in whole dollars.

Note: If you do not request additional withholding from your compensation, you may need to make estimated income tax payments using form IT 1040ES or estimated school district income tax payments using the SD 100ES. Individuals who commonly owe more in Ohio income taxes than what is withheld from their compensation include:

- Spouses who file a joint Ohio income tax return and both report income, and
- Individuals who have multiple jobs, all of which are subject to Ohio withholding.

Section III

This section is for individuals whose income is deductible or excludable from Ohio income tax, and thus employer withholding is not required. Such employee should check the appropriate box to indicate which exemption applies to him/her. Checking the box will cause your employer to not withhold Ohio income tax and/or school district income tax. The exemptions include:

- **Reciprocity Exemption:** If you are a resident of Indiana, Kentucky, Pennsylvania, Michigan or West Virginia and you work in Ohio, you do not owe Ohio income tax on your compensation. Instead, you should have your employer withhold income tax for your resident state. R.C. 5747.05(A)(2).
- **Resident Military Servicemember Exemption:** If you are an Ohio resident and a member of the United States Army, Air Force, Navy, Marine Corps, or Coast Guard (or the reserve components of these branches of the military) or a member of the National Guard, you do not owe Ohio income tax or school district income tax on your active duty military pay and allowances received while stationed outside of Ohio.

This exemption does not apply to compensation for nonactive duty status or received while you are stationed in Ohio.

R.C. 5747.01(A)(21).

- **Nonresident Military Servicemember Exemption:** If you are a nonresident of Ohio and a member of the uniformed services (as defined in 10 U.S.C. §101), you do not owe Ohio income tax or school district income tax on your military pay and allowances.
- **Nonresident Civilian Spouse of a Military Servicemember Exemption:** If you are the civilian spouse of a military servicemember, your pay may be exempt from Ohio income tax and school district income tax if all of the following are true:
 - Your spouse is a nonresident of Ohio;
 - You and your spouse are residents of the same state;
 - Your spouse is stationed in Ohio on military orders; and
 - You are present in Ohio solely to be with your spouse.

You **must** provide a copy of the employee's spousal military identification card issued to the employee by the Department of Defense when completing the IT 4.

As of 12/7/20 this new version of the IT 4 combines and replaces the following forms: IT 4 (previous version), IT 4NR, IT 4 MIL, and IT MIL SP.

Note: For more information on taxation of military servicemembers and their civilian spouses, see 50a U.S.C. §571.

- Statutory Withholding Exemptions: Compensation earned in any of the following circumstances is not subject to Ohio income tax or school district income tax withholding:
 - Agricultural labor (as defined in 26 U.S.C. §3121(g));
 - Domestic service in a private home, local college club, or local chapter of a college fraternity or sorority;
 - Services performed by an employee who is regularly employed by an employer to perform such service if she or he earns less than \$300 during a calendar quarter;

- Newspaper or shopping news delivery or distribution directly to a consumer, performed by an individual under the age of 18;
- Services performed for a foreign government or an international organization; and
- Services performed outside the employer's trade or business if paid in any medium other than cash.

*These exemptions are not common.

Note: While the employer is not required to withhold on these amounts, the income is still subject to Ohio income tax and school district income tax (if applicable). As such, you may need to make estimated income tax payments using form IT 1040ES and/or estimated school district income tax payments using form SD 100ES.

See R.C. 5747.06(A)(1) through (6).

To: _____

Attn: _____

Fax: 937-913-1410

**Drivers Attestation Agreement to Notify Employer
Disclosure under Fair Credit Reporting Act,
Consent to Procurement of Consumer Report for Employment Purposes and**

The undersigned hereby authorizes Choices in Community Living, Inc., or its insurance agency, or it assigned, to obtain copies of consumer reports, including a motor vehicle report, pertaining to me for employment purposes, and for use of rating and/or underwriting insurance for which the above names employer may apply, and any renewal thereof. I understand that in obtaining such consumer reports a consumer reporting agency may be used, and I do hereby authorize such use.

I _____ hereby attest that I have less than five (5) points on my driving record and will notify my employer of any accidents, moving violations or points being added to my drivers report; with the understanding that I am not permitted to transport in any vehicle without a valid driver license. You must notify Choices in Community Living within three (3) days of any moving violations or accidents.

Please initial the statements below to indicate you have read and understand each statement. If you have questions or need clarity ask the person who is processing you or someone in Human Resource.

___ I have five (5) points or less on my driving record

___ I give permission to have a driving report pull on my behalf

___ I will notify my employer (Choices in Community Living) within three (3) days of any accidents, moving violations or points added to my driving record

___ I give permission to Choices in Community Living permission to pull a consumer report

___ I understand that failure to make this notification within three (3) days may result in termination of employment

Social Security Number: _____

Driver License Number: _____

Date of Birth: _____

State: _____

Signature: _____ Date: _____

Print Name: _____

Approved: _____

Declined: _____

Personal Vehicle Safety Checklist

Completed by Employee

Name: _____ Date: _____

Vehicle: _____ Make: _____ Year: _____ License #: _____

AAA Member Yes ___ No ___ Membership#: _____ Exp. Date: _____

Insurance company Name: _____ Liability Amount: _____

Insurance Company Address _____

Policy#: _____ Expiration Date: _____

Driver License #: _____ Expiration Date: _____

Completed by Supervisor/HR Representative

Brake Pedal
 Interior Lights

Mirrors

Inside
 Outside

Windshield

Wipers

Fluid _____

Hazard Lights

Turn Signals

Left
 Right

Headlights

High Beams
 Low Beams

Brake Lights

Left
 Right

Tail Lights

Left
 Right

Horn

Exhaust System (noisy or loose) _____

Tires

Front
 Back
 Spare

Seat Belts

Front
 Back

Visual Inspection _____
(body/suspension)

MVR Prepared _____ MVR Sent: _____

All checked items found to be in good working order on _____. All unchecked items must be repaired before employee can use vehicle to transport CI/CL clients. Re-inspection date for unchecked items is _____.

Additional comments:

Supervisor's Signature: _____ Date: _____

Choices in Community Living

Drug Testing Consent for Applicants

Substance Abuse Test Consent and Release

By signing this form in the space provided below, I am consenting to undergo drug and/or alcohol testing upon the request of Choices in Community Living INC., either as part of the application process or after my hire. I authorize and direct any medical provider and/or laboratory to administer drug and/or alcohol testing and to release the test results to Choices in Community Living Inc. without further consent by me. I release such medical provider and laboratory and Choices in Community Living Inc. from all claims arising out of such testing. I understand that my refusal to undergo drug and/or alcohol testing will result in my application not being considered further, or, if employed, will result in my immediate termination.

Applicant's Signature

Date

Witness Signature

Date

ABUSER REGISTRY ANNUAL NOTICE

The Ohio Department of Developmental Disabilities (“Department”) maintains an Abuser Registry which is a list of employees who the Department has determined have committed one of the Registry offenses listed below. If your name is placed on the Registry you are barred from employment as a Developmental Disabilities employee in the state of Ohio. Because other state agencies require employers to check the Abuser Registry, placement on the Registry also prohibits you from being employed (1) by a Medicaid agency, being an owner (5 percent or more) of an agency or having a Medicaid Provider Agreement as a non-agency provider; (2) in a position to provide Ombudsman services or direct care services to anyone enrolled in a program administered by the Ohio Department of Aging; and (3) by a home health agency in a direct care position and may prevent you from being hired in a nursing home or residential care facility in a direct care position.

After 1 year, the person may petition the Department for removal of their name from the Registry. If the petition is denied, the name remains on the Registry.

The name of any “Developmental Disabilities (DD) employee” may be placed on the Registry. DD employee includes any Department employee, any employee of a county board of DD, an independent provider under Ohio Revised Code section 5123.16, and any employee providing specialized services to an individual with developmental disabilities. A specialized service is a program or service designed to primarily serve individuals with developmental disabilities including services by an entity licensed or certified by the Department.

Abuser Registry Offenses:

- **Physical Abuse** - the use of any physical force that could reasonably be expected to result in physical harm.
- **Sexual Abuse** - unlawful sexual conduct (unprivileged intercourse or other sexual penetration) and unlawful sexual contact (unprivileged touching of another’s erogenous zone).
- **Verbal Abuse** - purposely using words to threaten, coerce, intimidate, harass or humiliate an individual.
- **Prohibited Sexual Relations**- Consensual touching of an erogenous zone for sexual gratification and the individual is in the employee’s care and the individual is not the employee’s spouse.
- **Neglect** - when there is a duty to do so, failing to provide an individual with any treatment, care, goods or services necessary to maintain the health or safety of the individual.
- **Misappropriation (Theft)** - obtaining the property of an individual or individuals, without consent, with a combined value of at least \$100. Theft of the individual’s prescribed medication, check, credit card, ATM card and the like are also Registry offenses.
- **Failure to Report Abuse, Neglect or Misappropriation** - the employee unreasonably does not report abuse, neglect or misappropriation of the property of an individual with developmental disabilities, or the substantial risk to such an individual of abuse, neglect or misappropriation, when the employee should know that their non-reporting will result in a substantial risk of harm to such individual.
- **Conviction or plea of guilty to:** Offense of Violence - R. C. 2901.01, including convictions for the offense of Assault, Menacing, Domestic Violence or Attempting to commit any offense of violence; Sexual Offenses - R. C. Chapter 2907; Theft Offenses - R. C. Chapter 2913; Failing to provide for a functionally impaired person – R.C. 2903.16; Patient Abuse or Neglect - R.C. 2903.34; Patient Endangerment - 2903.341; and/or Endangering Children - 2919.22.

More information is available on the Department’s website under the Health and Safety tab.

The Registry website is at: https://its.prodapps.dodd.ohio.gov/ABR_Default.aspx.

Please call the Department at 614-995-3810 with any questions regarding the Registry.

✓ *I acknowledge receipt of the Abuser Registry Notice.*

Signature

Date

Choices in Community Living

Emergency Contact Information

Employee Name:

1st Contact Person:

Relationship:

Contact Number:

Alternative Number:

2nd Contact Person:

Relationship:

Contact Number:

Alternative Number:

Employee Confidentiality Agreement

Choices in Community Living

This Confidentiality Agreement ("Agreement") is made and effective upon date of hire by and between Choices in Community Living, Inc. (CICL) and employees.

1. **Confidential Information** - CICL proposes to disclose certain of its confidential and proprietary information (the "Confidential Information") to staff in the normal operations of conducting its business. Confidential Information shall include all data, materials, products, technology, computer programs, specifications, manuals, business plans, software, marketing plans, financial information, and other information disclosed or submitted, orally, in writing, or by any other media, to CICL staff by CICL. Confidential information disclosed orally shall be identified as such within five (5) days of disclosure. Nothing herein shall require CICL to disclose any of its information.
2. **CICL Staff's Obligations**
 - A. CICL staff agrees that the Confidential Information is to be considered confidential and proprietary to CICL and CICL staff shall hold the same in confidence, shall not use the Confidential Information other than for the purpose of its business with CICL, **and shall disclose it only to its officers, directors, or employees with a specific need to know.** CICL staff will not disclose, publish or otherwise reveal any of the Confidential Information received from CICL to any other party whatsoever except with the specific prior written authorization of CICL.
 - B. Confidential Information furnished in tangible form shall not be duplication by CICL staff except for purposes of this Agreement. Upon the request of CICL, CICL staff shall return all Confidential Information received in writing tangible form, including copies, or reproductions or other media containing such Confidential Information, within ten (10) days of such request. At CICL staff option, any documents or other media developed by CICL staff containing Confidential Information may be destroyed by CICL staff. CICL staff shall provide a written certificate to CICL regarding destruction within ten (10) days thereafter.
3. **Term** - The obligations of CICL staff herein shall be effective upon hiring and/or the signing of this agreement from the date CICL last discloses any Confidential Information to CICL staff pursuant to this Agreement. Further, the obligation not to disclose shall not be affected by bankruptcy, receivership, assignment, attachment or seizure procedures, whether initiated by or against CICL staff, nor by the rejection of any agreement between CICL and CICL staff, by a trustee of CICL staff in bankruptcy or by the CICL staff as a debtor-in-possession or the equivalent of any of the foregoing under local law.
4. **Other Information** - CICL staff shall have no obligation under this Agreement with respect to Confidential Information which is or becomes publicly available without breach of this Agreement by CICL staff; is rightfully received by CICL staff without obligations of confidentiality; or is developed by CICL staff without breach of this Agreement; provide, however, such Confidential Information shall not be disclosed until thirty (30) days after written notice of intent to disclose is given to CICL along with the asserted grounds for disclosure.
5. **No License** - Nothing contained herein shall be construed as granting or conferring any rights by license or otherwise in any Confidential Information. It is understood and agreed that neither party solicits any change in the organization, business practice, service or products of the other party, and that the disclosure of Confidential Information shall not be construed as evidencing any intent by a party to purchase any products or services of the other party nor as an encouragement to expend funds in development or research efforts. Confidential Information as a basis upon which to develop or have a third party develops a competing or similar product.
6. **No Publicity** - CICL staff agrees not to disclose its participation in this undertaking, the existence or terms and conditions of the Agreement, or the fact that discussions are being held with CICL.
7. **Governing Law and Equitable Relief** - This Agreement shall be govern and construed in accordance with the laws od the United States and the State of Ohio and CICL Staff consents to the exclusive jurisdiction of the state courts and U.S. federal courts located there for any dispute arising out of this Agreement. **CICL staff agrees that in the event of any breach or threatened breach by CICL staff, CICL may obtain, in addition to any other legal remedies which may be available, such equitable relief as may be necessary to protect CICL against any such breach or threatened breach.**
8. **Final Agreement** - This Agreement terminates and supersedes all prior understandings or agreement on the subject matter hereof. This Agreement may be modified only by further writing that is duly executed by both parties.
9. **No Assignment** - CICL staff may not assign this Agreement or any interest herein without CICL's express prior written consent.
10. **Severability** - If any term of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, then this Agreement, including all of the remaining terms, will remain in full force and effect as if such invalid or unenforceable term had never been included.
11. **No Implied Waiver** - Either party's failure to insist in any one or more instances upon strict performance by the other party of any of the terms of this Agreement shall not be construed as a waiver of any continuing or subsequent failure to perform or delay in performance of any term hereof.

Staff Signature _____ Date _____

(HIPPA Compliance)

Attestation and Agreement to Notify Employer

Choices In Community Living, Inc.

- ✓ I hereby attest that I **HAVE** _____ OR I **HAVE NOT** _____ been convicted of, plead guilty to, or been found eligible for intervention in lieu of conviction for any of the disqualifying offenses listed below **AND** I agree that I will notify Choices In Community Living, Inc. within 14 calendar days, if while employed I am formally charged with, am convicted of, or (Employer's Name) plead guilty to one of the disqualifying offenses. I understand that failure to make this notification may result in termination of employment. **(If you have been convicted or plead guilty to any of the disqualifying offenses, please note below on this agreement by the corresponding offense)**
- ✓ I understand that, that my employer is entitled to information regarding all convictions, guilty pleas, or interventions in lieu of conviction and **that I must disclose such expunged or sealed convictions or records to my employer.**
- ✓ I agree to notify above name employer immediately, if while employed, I accumulate six or more points on my driving record or if my driver's license is suspended or revoked.
- ✓ I attest and affirm, I **HAVE** _____ OR I **HAVE NOT** _____ been a resident of Ohio for the past five (5) years.
- ✓ I grant permission to the above named employer to conduct any and all required and necessary background checks on me for the purpose of determining suitability and eligibility for employment. The fees for the required background checks have been explained and I understand that the cost is my responsibility (cost may vary as deemed appropriate by the employer).
- ✓ I applicant understand that the accuracy of this information is a condition of employment and that my employer is relying on the accuracy of this information in making any offer of employment to the applicant.
- ✓ I understand that I may be discharged if any of the above information is false, incomplete, or misleading.
- ✓ By initialing and signing this form I am stating that the above information is complete, true and accurate under penalty of perjury.

(Applicant's Signature)

(Applicant's Name Printed)

(Date Signed)

Tier 1 Disqualifying Offenses (Permanent Exclusion):

2903.01 (aggravated murder)
2903.02 (murder)
2903.03 (voluntary manslaughter)
2903.11 (felonious assault)
2903.15 (permitting child abuse)
2903.16 (failing to provide for a functionally impaired person)
2903.34 (patient abuse and neglect)
2903.341 (patient endangerment)
2905.01 (kidnapping)
2905.02 (abduction)
2905.32 (human trafficking)
2905.33 (unlawful conduct with respect to documents)
2907.02 (rape)
2907.03 (sexual battery)
2907.04 (unlawful sexual conduct with a minor, formerly corruption of a minor)
2907.05 (gross sexual imposition)
2907.06 (sexual imposition)
2907.07 (importuning)
2907.08 (voyeurism)
2907.12 (felonious sexual penetration)
2907.31 (disseminating matter harmful to juveniles)

2907.32 (pandering obscenity)
2907.321 (pandering obscenity involving a minor)
2907.322 (pandering sexually oriented matter involving a minor)
2907.323 (illegal use of minor in nudity-oriented material or performance)
2909.22 (soliciting/providing support for act of terrorism)
2909.23 (making terrorist threat)
2909.24 (terrorism)
2913.40 (Medicaid fraud)
2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list
2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list
2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
A conviction related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct involving a federal or state-funded program, excluding the disqualifying offenses set forth in section 2913.46 of the Revised Code (illegal use of supplemental nutrition assistance program [SNAP] or women, infants, and children [WIC] program benefits).
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.

Tier 2 Disqualifying Offenses (Ten-Year Exclusion):

2903.04 (involuntary manslaughter)
2903.041 (reckless homicide)
2905.04 (child stealing) as it existed prior to July 1, 1996
2905.05 (criminal child enticement)
2905.11 (extortion)
2907.21 (compelling prostitution)
2907.22 (promoting prostitution)
2907.23 (enticement or solicitation to patronize a prostitute, procurement of a prostitute for another)
2909.02 (aggravated arson)
2909.03 (arson)
2911.01 (aggravated robbery)
2911.11 (aggravated burglary)
2913.46 (illegal use of supplemental nutrition assistance program [SNAP] or women, infants, and children [WIC] program benefits)
2913.48 (workers' compensation fraud)
2913.49 (identity fraud)
2917.02 (aggravated riot)
2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list
2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list
2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
2923.12 (carrying concealed weapon)
2923.122 (illegal conveyance or possession of deadly weapon or dangerous ordnance in a school safety zone, illegal possession of an object indistinguishable from a firearm in a school safety zone)
2923.123 (illegal conveyance, possession, or control of deadly weapon or dangerous ordnance into courthouse)
2923.13 (having weapons while under disability)
2923.161 (improperly discharging a firearm at or into a habitation or school)
2923.162 (discharge of firearm on or near prohibited premises)
2923.21 (improperly furnishing firearms to minor)
2923.32 (engaging in pattern of corrupt activity)
2923.42 (participating in criminal gang)
2925.02 (corrupting another with drugs)
2925.03 (trafficking in drugs)
2925.04 (illegal manufacture of drugs or cultivation of marihuana)
2925.041 (illegal assembly or possession of chemicals for the manufacture of drugs)
3716.11 (placing harmful objects in food or confection)
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.

Tier 3 Disqualifying Offenses (Seven-Year Exclusion):

959.13 (cruelty to animals)
959.131 (prohibitions concerning companion animals)
2903.12 (aggravated assault)
2903.21 (aggravated menacing)
2903.211 (menacing by stalking)
2905.12 (coercion)
2909.04 (disrupting public services)
2911.02 (robbery)
2911.12 (burglary)
2913.47 (insurance fraud)
2917.01 (inciting to violence)
2917.03 (riot)
2917.31 (inducing panic)
2919.22 (endangering children)
2919.25 (domestic violence)
2921.03 (intimidation)
2921.11 (perjury)
2921.13 (falsification, falsification in theft offense, falsification to purchase firearm, or falsification to obtain a concealed handgun license)
2921.34 (escape)
2921.35 (aiding escape or resistance to lawful authority)
2921.36 (illegal conveyance of weapons, drugs, or other prohibited items onto grounds of detention facility or institution)
2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list
2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list
2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
2925.05 (funding of drug or marijuana trafficking)
2925.06 (illegal administration or distribution of anabolic steroids)
2925.24 (tampering with drugs)
2927.12 (ethnic intimidation)
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.

Tier 4 Disqualifying Offenses (Five-Year Exclusion):

2903.13 (assault)
2903.22 (menacing)
2907.09 (public indecency)
2907.24 (soliciting after positive human immunodeficiency virus test)
2907.25 (prostitution)
2907.33 (deception to obtain matter harmful to juveniles)
2911.13 (breaking and entering)
2913.02 (theft)
2913.03 (unauthorized use of a vehicle)
2913.04 (unauthorized use of property, computer, cable, or telecommunication property)
2913.05 (telecommunications fraud)

2913.11 (passing bad checks)
2913.21 (misuse of credit cards)
2913.31 (forgery, forging identification cards)
2913.32 (criminal simulation)
2913.41 (defrauding a rental agency or hostelry)
2913.42 (tampering with records)
2913.43 (securing writings by deception)
2913.44 (personating an officer)
2913.441 (unlawful display of law enforcement emblem)
2913.45 (defrauding creditors)
2913.51 (receiving stolen property)
2919.12 (unlawful abortion)
2919.121 (unlawful abortion upon minor)
2919.123 (unlawful distribution of an abortion-inducing drug)
2919.23 (interference with custody)
2919.24 (contributing to unruliness or delinquency of child)
2921.12 (tampering with evidence)
2921.21 (compounding a crime)
2921.24 (disclosure of confidential information)
2921.32 (obstructing justice)
2921.321 (assaulting/harassing police dog or horse/service animal)
2921.51 (impersonation of peace officer)
2923.01 (conspiracy) when the underlying offense is any of the offenses or violations on this list
2923.02 (attempt) when the underlying offense is any of the offenses or violations on this list
2923.03 (complicity) when the underlying offense is any of the offenses or violations on this list
2925.09 (illegal administration, dispensing, distribution, manufacture, possession, selling, or using any dangerous veterinary drug)
2925.11 (drug possession other than a minor drug possession offense)
2925.13 (permitting drug abuse)
2925.22 (deception to obtain dangerous drugs)
2925.23 (illegal processing of drug documents)
2925.36 (illegal dispensing of drug samples)
2925.55 (unlawful purchase of pseudoephedrine product)
2925.56 (unlawful sale of pseudoephedrine product)
A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations on this list.

TIER 5 (No Exclusion):

The employer may employ an applicant or continue to employ an employee if the applicant or employee has been convicted of, pleaded guilty to, or been found eligible for intervention in lieu of conviction for any of the following sections of the Revised Code:

2925.11 (Drug possession that is minor drug possession offense)
2925.14 (Illegal use or possession of drug paraphernalia)
2925.141 (Illegal use or possession of marijuana drug paraphernalia)
A violation of an existing or former municipal ordinance or law of this state, or any other state, or the United States that is substantially equivalent to any of the offenses or violations described in this tier of this Exhibit

FURTHER AFFIANT SAYETH NAUGHT.

Signature of Affiant

Date: _____

Sworn to and subscribed before me at _____, Ohio, this ___ day of _____, 20__.

Notary Public

My commission expires:

CHOICES IN COMMUNITY LIVING POSITION DESCRIPTION

Job Title: Direct Support Specialist (DSP)

Reports To: Program Manager

Primary Function: Provides services and support in all aspects of daily living to individuals with developmental disabilities.

Essential Job Duties:

Client Care:

- Provide assistance with activities of daily living in accordance with each client's Individual Service Plan (ISP).
- Assistance with personal care including but not limited to Intimate hygiene, shaving, toileting, bathing, brushing and flossing teeth.
- Assistance with all aspects of laundry including but not limited to washing, drying, folding, putting items away and ironing.
- Prepare and cook meals in accord with dietary needs and restrictions.
- Feeding clients as needed and in accord with the ISP.
- Assistance with dressing clients and helping them choose weather appropriate attire for the day.
- Develop and maintain open communication with clients using communication techniques including sign language, gestures, written or verbal methods etc.
- Find inventive ways to encourage client's independence in making their own decision and help clients to develop sound judgement (i.e. not wearing a sweater on a hot day).
- Grocery shopping for the client using the tax exempt status when appropriate.
- Shopping for the client's clothing, personal and household supplies as needed.
- Conduction fire drills, severe weather drills and other required trainings for client's safety and well-being.
- Cleaning and disinfecting clothing, household items, van and any other affected items soiled by the client's bodily fluids.

Client Rights:

- Develop and maintain a good working relationship with the clients, treating them at all times with dignity and respect.
- Ensure that clients are encouraged to make their own decisions in day to day activities (i.e. meals, clothing, activities, time of day that chores are completed, etc.)
- Promote the development of meaningful relationships and with other clients, neighbors and friends.

- Keep accurate records and documentation including but not limited to billing sheets, medication administration records, HAB sheets, skill development goal sheets, census, client records, program records, money ledgers, behavior plans and unusual incident forms
- Document and report any potential unusual incidents in a timely manner
- Provide required documentation as needed to maintain employee files including but not limited to current driver license, current auto insurance, current documentation showing renewal of required trainings, etc.

Professionalism:

- Attend every "All Staff" meeting and required renewal class as set by the program administrator/manager and the HR department
- Maintain proper attire at all times/clothing must be appropriate for scheduled activities
- Maintain professional attitude and actions in the program and the community
- Assume responsibility for decisions and actions
- Recognize the importance of modeling valued behaviors to clients, co-workers, supervisors and community personnel
- Recognize that although the job is performed in a home environment it is *your* work environment and behavior at all times needs to reflect professionalism.

POSITION REQUIREMENTS

Education:

Possesses a minimum of a high school diploma or equivalent (GED) and strong reading, writing and oral communication skills as well as basic math skills

Prior Experience:

General care giving experience preferred but not required

Physical Requirements:

Ability to engage in strenuous physical activities including but not limited to lifting (at least 50 pounds), standing, walking, carrying, bending, reaching, stooping, etc.

Additional Requirements:

Ability to concentrate, take initiative, cope with stress, manage multiple tasks, adapt to and remain alert in an unsupervised environment, use independent judgment to accomplish required tasks and secure desired results, maintain composure in all interactions

Must Possess:

1. A valid Ohio driver license
2. Current State required auto insurance
3. For additional requirements refer to Conditional Employment Requirements.

Employee's Statement of Residence

City Income Tax

**To: Choices in Community Living, Inc.
1651 Needmore Road
Dayton, OH 45414**

From: _____
Employee's Name (Please Print)

My residence (for City Income Tax purpose) is:

Address City State Zip Code

My residence is in the corporate limits of one of the following cities or villages

No _____ Yes _____ (if yes, circle city or village)

(if no, list city _____)

Brookville	Germantown	Tipp City
Cedarville	Huber Heights	Trotwood
Centerville	Kettering	Troy
Dayton	Oakwood	Vandalia
Englewood	Phillipsburg	West Milton
Farmersville	Riverside	Yellow Springs

I furnish this information for the purpose of enabling you, my employer, to determine your liability under Section 6 of the City Income Tax Ordinances for withholding city income tax on my compensation earned, and should my status change, insofar as my residence is concerned, I will notify you, my employer, immediately.

Employee's Signature Date

Employee's Social Security Number



1651 Needmore Rd Dayton, OH 45414 937-898-2220

Date: _____

I _____ understand that maintaining automobile insurance is a requirement for employment with Choices in Community Living. I agree to obtain insurance and provide documentation to the office by _____ . I understand and agree that until the time when documentation is provided I will not under any circumstances transport a CICL client or do any work on behalf of CICL that would require driving.

Attached is Policy #26 "Conditional Employment"

Staff Signature/Print/Date: _____ / _____ / _____

Program Director/Program Administrator: _____ / _____

Human Resource Representative/ Date: _____ / _____

General Employment Information

Name: _____ Date: _____

1. Disclaimer - General Statement: Employment with Choices in Community Living does not constitute a contractual employment relationship for any definite period. Continued employment is not guaranteed, nor is it a right. Employment by Choices in Community Living is terminable by either Choices in Community Living or an employee at any time for any reason. Employees who voluntarily resign their position are requested to provide at least a two (2) week written notice.
2. Reassignments: According to the needs of our clients, Choices in Community Living Inc. reserves the right to reassign job site work schedules and responsibilities.
3. Termination with Cause: Any serious breach of the job description or personnel policies and/or Program Services policies may be deemed grounds for termination of employment with cause.
4. Employment Classification: the employee's position classification is as indicated:
A) Full-Time ____ B) Part-Time ____ C) Scheduled Substitute ____ D) Substitute ____
5. Compensation:
A) Hourly – Employee shall receive an hourly rate of _____
B) Salary – Employee shall receive an annual salary of _____, *★*
payable in two-week intervals *attach the schedule*
6. Benefits: Upon successful completion of ninety (90) days of employment, regular full-time or regular part-time employees become eligible for benefits. (See attachment)
7. Compliance:
A) Choices in Community Living, in compliance with MRDD Rules of Licensure, requires new employees receive a physician's certification for fitness to carry out the duties of their jobs by way of a physical and negative tuberculosis skin test or negative chest x-ray, as a condition of employment. Choices in Community Living will pay the cost of these medical examination/tests and will provide an agency approved physician.
B) Choices in Community Living, in compliance with MR/DD Rules of Licensure, requires employees to have and maintain a valid Ohio driver's license, an automobile in good working order, proof of insurance and a satisfactory driving record that is acceptable to the agency insurance provider.

Employee Signature

Date

Witness Signature

Date

Choices In Community Living

Electronic Signature Acknowledgement

Choices In Community Living utilizes electronic documentation in some instances that requires employees to provide an electronic signature upon document completion. This acknowledgement is to make employees aware that by submitting an electronic signature, they are providing an electronic mark that is held to the same standard as a legally binding equivalent of a handwritten signature provided by a signee. For purposes of the acknowledgement, an original signature is considered a legal First and Last name (legal name may include middle name, initial or suffix) followed by the date. Choices In Community Living obtains Medicaid funding from CMS and The Ohio Department of Developmental Disabilities. Choices in Community Living utilizes an electronic documentation system to meet the requirements of the Medicaid program. Your documentation into these system require the use of a user name and password and electronic signature. This documentation will be used for Medicaid billing purposes for services that you provide while employed by Choice In Community Living.

AGREEMENT: By signing this Electronic Signature Acknowledgment Form, I agree that my electronic signature is the legally binding equivalent to my handwritten signature. Whenever I execute an electronic signature, it has the same validity and meaning as my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding.

Employee Signature

Print Name

Date

CONFIDENTIALITY FORM

RESPONSIBILITY OF CONFIDENTIALITY

1. I understand and agree to maintain and safeguard the confidentiality of privileged information of Choices In Community Living, Inc. Further, I understand that any unauthorized use or disclosure of information residing on the Organization's information resource system may result in disciplinary action consistent with the policies and procedures of federal, state, and local agencies.

I understand that within the scope of my duties I may need to photograph and share information about a resident or client on my personal mobile device or personal e-mail account. I understand that any such images and corresponding communication are confidential, and I pledge to share such information only with those having an authorized need to know. I pledge to delete any such images and corresponding communications once my work-related tasks are completed. I will not share or discuss any such images or information in any way outside the course of pursuing necessary aid to clients.

Date

Signature

CHOICES IN COMMUNITY LIVING, INC.

Date

Authorized Signature
(Privacy Officer)

Application for Personnel to Attend the DODD Medication Administration (MA) Certification Course

Page 2 must be completed by DD personnel.

Prior to attending a DODD MA Certification Course: DD Personnel are required to complete this application, including all information and signatures. Without a completed application DD Personnel will not be eligible for DODD Medication Administration certification to administer medications.

This application is for

- | | | |
|---|--|---|
| <input type="checkbox"/> (Cat. 1) Medication Administration | <input type="checkbox"/> (Cat. 2) G/J Tube Medications | <input type="checkbox"/> (Cat. 3) Insulin |
| <input type="checkbox"/> (Cat. 1) Renewal | <input type="checkbox"/> (Cat. 2) Renewal | <input type="checkbox"/> (Cat. 3) Renewal |

Have you ever taken a medication administration certification class before this application? Yes No

First name	Last name	Last 4 of SSN	Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Are you an independent provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, do you have (must provide proof to RN Trainer) <input type="checkbox"/> High school diploma <input type="checkbox"/> High school equivalency document		
Personal street address	City	State	Zip	County
Home phone	Work phone	Cell phone	Email	
At the time of this application, do you work for more than one DD employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, print the names and provider number of all DD employers you currently work for DD employer _____ Provider number _____ DD employer _____ Provider number _____			

I attest that all information provided in this application is true, current, and correct.

Signature of DD personnel _____ Date _____

RN trainer should keep this application in a retrievable file, which is accessible to authorized personnel and DODD upon request for at least 7 years.

RN trainer signature _____ Date _____ Session number _____
(Includes validation of HSD/GED for independent providers) (If initial certification, not renewal)

WEBSITE CONSENT FORM

I, _____, hereby grant permission to Partner for Community Living, and/or Choices In Community Living, Inc. and Resident Home Association to use the following information on any or all of their websites.

- I understand that the website may include agency newsletters, annual reports, donor recognition, event information (including names of sponsors, photos from events) and other information promoting Partners for Community Living, Choices In Community Living, Inc. and the Resident Home Association.
- I understand that no identifying information other than my name and/or photo will be included on the website (no personal addresses, amounts of donations or sponsorships – other than donor or sponsor levels – etc.
- I understand that my consent will begin with the date on this form and will remain in effect until such time that I notify Partners for Community Living and/or Choices in Community Living or the Resident Home Association that I revoke my consent.

Please check one of the following statements:

- Yes, my name and photo may be used on websites
- My name only may be used on websites
- My photo only may be used on websites
- No, do not use my name or photo on website

Signature _____ Date _____

WEB CHECK WAIVER

I hereby certify that I have given agency (4CV155-Choices in Community Living) permission to obtain all criminal information pertaining to me in the files of the Ohio Bureau of Criminal Identification and Investigation (BCI&I) and all applicable registry checks per ORC 5123-2-08.

By placing my fingerprint images on the WEBCHECK Scanner, I am authorizing BCI&I to release criminal history information about me to the person(s)/agencies identified in this request.

I hereby release BCI&I and any and all individuals identified in this request from all liability in connection with the dissemination of such criminal history information.

Signature _____ Date _____

Choices in Community Living, Inc.

Employee's Statement of Physical Disability

Employee Name

Social Security Number

Hire Date

I am being or have been treated for the following physical disabilities:
(Please check yes or no)

	Yes	No		Yes	No
Epilepsy	0	0	Diabetes	0	0
Cardiac Arrest	0	0	Arthritis	0	0
Amputations	0	0	Loss of sight or partial loss	0	0
Poliomyelitis	0	0	Cerebral Vascular Accident	0	0
Multiple Sclerosis	0	0	Parkinson's disease	0	0
Cerebral Palsy	0	0	Tuberculosis	0	0
Silicosis	0	0	Psycho-Neurotic Disability	0	0
Hemophilia	0	0	Chronic Osteomyelitis	0	0
Ankylosis of Joint	0	0	Hyperinsulinism	0	0
Muscular Dystrophies	0	0	Arteriosclerosis	0	0
Thrombophlebitis	0	0	Varicose Veins	0	0
Fire Fight's cardiovascular or pulmonary diseases (See below)	0	0			
Coal Miner's pneumoconiosis "black lung disease"	0	0			
Completion of an Approved Rehabilitation Program	0	0			
Back Injury	0	0			

Only need to fill below section if served in the military.

If #23 is marked YES, which fire department were you employed by? _____
How long employed? _____

Have you received compensation for an industrial injury or disease? _____
Who were you employed by? _____ Nature of injury: _____
Claim Number: _____

Have you been in U.S. Military Service? Yes _____ No _____ How long? _____
Are you receiving Military Disability Compensation? Yes _____ No _____ Nature of Disability: _____
Have you applied for Military Disability? Yes _____ No _____

Name of Family Doctor _____
Address: _____

I certify that to the best of my knowledge the above statement concerning my past medical history are true.

Signature _____ Date _____

Choices in Community Living

Emergency Contact Information

Employee Name:

1st Contact Person:

Relationship:

Contact Number:

Alternative Number:

2nd Contact Person:

Relationship:

Contact Number:

Alternative Number:

To: Acordia

Attn: _____

Fax: 937-913-1410

**Disclosure Under
Fair Credit Reporting Act
And
Consent to Procurement of Consumer Report
For
Employment Purposes**

The undersigned hereby authorizes Choices in Community Living, Inc., or its insurance agency Acordia, or it assigns, to obtain copies of consumer reports, including a motor vehicle report, pertaining to me for employment purposes, and for use on rating and/or underwriting insurance for which the above-named employer may apply, and any renewal thereof. I understand that in obtaining such consumer reports a consumer reporting agency may be used, and I do hereby authorize such use.

Signature: _____ Date: _____

Print Name: _____

Social Security Number: _____

Driver License Number: _____

Date of Birth: _____

State: _____

Approved: _____

Declined: _____