bp senior care
Home health care &nursing

930 E County Line Rd Suite 1
Lakewood, NJ 08701
Phone (732) 363-0364 / Fax (732) 363-0365

Interview Form

Name of applicant: _____

Position being applied for: _____

Date: _____

	Check when completed
Review of job description	☐
Review of requirements	☐
Review of application	☐
Review of education and experience	☐
Review of skills checklist	☐
Review of required testing	☐
Availability: days, times, and service area	☐
Interview was conducted in person	☐

Comments:

Name of Interviewer (print): _____Title _____

Signature of Interviewer _____Date: ____/____/_____

Date Implemented: ____/____/_____
Date Revised: ____/____/_____

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OFFICE USE ONLY

Referred By: _____

Paycheck: _____ Mail _____ Pick up _____

EMPLOYMENT APPLICATION EVALUATION SHEET

Male Female

Caregiver Name:			Proceed with hiring process Y N
Interview Date:	On Time Y N	Eye Contact Y N	Knowledge of BP Y N
Interviewer:	Additional Notes:		
Transportation:	**Car: Y N License Y N Will Drive Client Y N**		
Impression:		BG Check:	Physical Sub:
Availability/Preferences:			

– SKILLS AND EXPERIENCE CHECKLIST –

	Y	N	Comments & Skill Level		Y	N	Comments & Skill Level
Housekeeping, Cleaning				AIDS Client Experience			
Meal Preparation/ Planning				ALS Client Care Experience			
Kosher Experience				Alzheimer's/Dementia Experience			
Shopping, Errands				Child Care Experience			
				Facility Experience			
ADL, Assistance Experience				Hospice Experience			
Ambulation Experience				Mental Health Clients			
Bath, Shower Chairs				Mental Retardation Clients			
Post Mortem Care				MS Client Care Experience			
Incontinence, Diapers				Cardio-Pulmonary Resuscitation			
Transfers, Commodes				Other Certification Training			
Medication Reminders				First Aid			
Dental Hygiene Assistance				Universal Precautions			
Sensitive Skin Care				Will Work With AIDS Clients			
				Will Work With Men			
Catheter, External Genital Care				Will Work With Women			
Colostomy Assistance				Will Work With "Social Drinker"			
Dressings/Bandages				Will Work With Pets			
Enema Assistance				Will Work With "Smoker"			
Hoyer, Other Mechanical Lift							
Range of Motion Exercises				Allergies			
Saliva Suctioning							
				Communication Skills			
Mechanical Bed Operation				Reading Ability			
Wheelchair, Walkers, Canes				Are you a Smoker			
Primary Language				**Other skills not listed**			
Other Language Spoken							

NOTES:_____

_____

_____

_____

Interviewer Signature Title Date Supervisor/RN/Manager Signature Title Date

Revised 07/2024

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Name:			**Position Applying for:**
Last (Print)	**First (Print)**	**Middle Initial**	**SS# _____ - _____ - _____**
Street Address:			Phone Number:
Street Address:		Apt/Floor No:	
City:		State/Zip:	

Are there any other names you have used in your present or past work experience?

Education:

School/College (include city/state)—begin with last institution attended	**Degree Earned**	**Year**

Employment History:

Employer	**Location**	**Phone Number**	**Immediate Supervisor**	**Employment Dates From**	**To**

Work Availability: ☐ between 9 AM and 5:00 PM **WEEKDAYS** ☐ between 9 AM and 5:00 PM **WEEKENDS** ☐ Other_____

Please list any and all areas of actual working experience and period of time during which experience was acquired (for example, ICU – one year, med surg, etc.):

Please explain, in detail, any periods of unemployment or reasons for leaving each employer:
Why are you interested in this position?
What special qualifications do you have that would be helpful in this position (e.g., speak a foreign language, proficient with specific computer programs)?
Type of license/certification, issuing authority and number, if applicable, license/certification expiration date:
Malpractice insurance carrier name, address, policy number, expiration date if applicable:

Professional References: Name	**Address**	**Phone Number**

Please read before signing:

My signature verifies that information provided in this application is true and complete. I understand the agency is an Equal Opportunity Employer. I understand that falsification, including withholding of information, on this application is grounds for immediate dismissal if I am selected for a position. I further understand that if I am hired, I can be terminated, with or without cause and with or without notice. I agree to have my picture taken for identification purposes and to submit to drug screening tests, upon request. I understand that all references listed above may be contacted in addition to past employers and educational institutions**:**

I, (Applicant)_____, hereby authorize (Agency)_____ to request and receive from all prior employers within one (1) year of the date of this application, any and all pertinent information concerning my prior employment and its termination, including the reasons for such termination.

Signed_____ Date Click or tap to enter a date.

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Work History Verification

TOP SECTION COMPLETED BY APPLICANT

TO:

Previous Employer:	**Job Title: (Position Held)**	**Employment Dates:** From: To:
Supervisor:	**Phone:**	**FAX:**
Employer Street Address:	**City & State**	**Zip Code**

FROM:

Applicant Name	**Position Applied For**	
Applicant Signature	*I, (applicant) hereby authorize (agency) to request and receive from all prior employers within one year of the date of application, any and all pertinent information concerning my prior employment and its termination, including the reasons for such termination.*	**Date**

Agency HR Work History Verification

BOTTOM SECTION COMPLETED BY AGENCY

Today's Date:	
Employer Contacted:	
Name/Title of person providing info /Phone #	
Applicant Name:	
Dates of Employment:	
Position Held by this person	
Employment History Confirmed	**Yes or No**

Agency HR Work History Verification
BOTTOM SECTION COMPLETED BY AGENCY
(Cont.)

Reason for termination, resignation or cessation of employment	
Were there issues related to this person's departure that would cause concern (i.e. violence, threats of violence, dishonesty, theft)? If so, please explain.	
Written verification: signature/title of the Work History and date	**Yes or No**
Verbal Verification: signature/title of staff member who obtained the information and date.	
Additional Notes:	
Name and title of person conducting the check:	
Signature/Date:	

Rev. _____

BP Senior Care

Reference Request

Reference Type: ☐Employer ☐Educational

TOP SECTION TO BE COMPLETED BY APPLICANT

Reference Name: _____ Employment Dates: From: _____to _____

TO: Supervisor _____ Phone: _____

City: _____ State: ____ Zip: _____ Fax: _____

FROM: Applicant Name (print): _____ Position Held: _____

I HEREBY REQUEST AND AUTHORIZE THE AGENCY TO REQUEST AND RECEIVE FROM ALL PRIOR EMPLOYERS WITHIN ONE YEAR OF THE DATE OF APPLICATION, ANY AND ALL PERTINENT INFORMATION CONCERNING MY PRIOR EMPLOYMENT AND ITS TERMINATION, INCLUDING THE REASONS FOR SUCH TERMINATION. I AGREE TO HOLD HARMLESS THESE PERSONS OR ORGANIZATIONS, THEIR OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS OF LIABILITY, CLAIMS, DAMAGES OR DEMANDS OF ANY NATURE ARISING FROM OR RELATED TO THE INVESTIGATION OF INFORMATION CONTAINED IN MY APPLICATION.

Position applied for: _____

Signature of Applicant: _____ Date: _____

CURRENT OR PREVIOUS EMPLOYER PLEASE COMPLETE THIS SECTION

OR AGENCY STAFF MEMBER DURING TELEPHONE VERIFICATION

ALL INFORMATION PROVIDED WILL BE KEPT CONFIDENTIAL

☐Confirmed Dates of Employment

	Poor	Average	Good	Excellent
Quality of work	_____	_____	_____	_____
Attendance	_____	_____	_____	_____
Punctuality	_____	_____	_____	_____
Dependability	_____	_____	_____	_____
Competency	_____	_____	_____	_____
Cooperation	_____	_____	_____	_____

Would you rehire this applicant? _____

Comments: _____

Name of Person completing reference (print): _____

Position or Title: _____ Facility Phone Number: _____

Signature: _____ Date : _____

TELEPHONE VERIFICATION DOCUMENTATION

Date of Call _____ Agency Representative _____

Person Contacted _____ Title _____

Notes _____

Signature of Agency Representative: _____

Rev. _____

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New Employee Orientation Guideline/Checklist

For All Employees:

___ Attendance, Dress Code, Job Descriptions, Evaluations, Payroll Procedure
___ Completion of all employment forms
___ Confidentiality Plan
___ Disaster Plan
___ Emergency Plan
___ General orientation to the organization: agency philosophy and mission
___ HIPAA: Patient privacy right policy, corporate compliance
___ Human Resource Process
___ Introduction to Agency employees
___ On Call Procedure
___ Patient referrals
___ Quality Improvement
___ Review of organizational chart
___ Risk Management
___ Safety review (in office): Drug free work place
___ Scope of services provided by the agency: Home Maker Home-Health Aide and/or Skilled Nursing
___ Tour of office

All Field Staff:

___ Attendance
___ Competency
___ Dress Code
___ Evaluations
___ Health Requirements
___ Home safety issues
___ Human Resource Process
___ Job Descriptions
___ License/Certification validation
___ Process for communicating patient information among field clinicians on multiple shift cases
___ Scope of services provided by the agency: Home Maker Home-Health Aide and/or Skilled Nursing
___ Staffing
___ Supervisory Visits (clinical and administrative)

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New Employee Orientation Guideline/Checklist

CPCS:

___ In-Service Education
___ Introduction to Home Care for Nursing Supervisors who do not have one (1) year of professional experience as a RN, including the preceptor program
___ Patient's Rights and Responsibilities, Advance Directive
___ Plan of Care/Activity Sheet: documentation
___ Reporting Procedure
___ Review of Exposure Control Policy:(identification, handling and disposal of hazardous or Infectious materials)
___ Review of general patient and environmental changes that require an immediate report by phone to a nurse

Mandatory Initial In-Service Topics:

	Length of time for topic
___ Abuse: Elder, Child & Domestic Violence	_____
___ Administrative and Clinical Policies & Procedures and HIPAA	_____
___ Alzheimer's Disease	_____
___ Back Safety	_____
___ Blood Borne Pathogens	_____
___ Corporate Compliance	_____
___ Employee Safety	_____
___ Ethics in Home Health	_____
___ Fraud & Abuse Protection	_____
___ Human Trafficking	_____
___ Infection Control	_____
___ Needle Stick Safety	_____
___ Pain Management	_____
___ Standard Precautions	_____
___ Workforce Protection	_____

Administrative Hours: _____
In-Service Hours: _____
Total Hours: _____

Employee Name (print): _____ Title: _____

Employee Signature: _____Date: ____/____/_____

Instructor Name (print): _____ Title: _____

Instructor Signature: _____Date: ____/____/_____

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RECORD OF ORIENTATION / IN-SERVICE EDUCATION

R.N._____ L.PN. _____ CNA _____ CHHA_____ COMPANION _____

Initial _____ Annual_____

Topic	Time Allotted
Infection Control and Prevention Blood Borne Pathogens Infection Control Standard Precautions Needle Stick Safety	**(1 hour x 4)**
Employee Safety and Work Etiquette Corporate Compliance Employee Safety	**(1 hour x 2)**
Home Safety and Abuse Awareness Child Abuse Elder Abuse Domestic Violence Human Trafficking Awareness Alzheimer's and Dementia Awareness	**(1 hour x 5)**
Pain Management	**(1 hr)**

Employee:_____ **Date:**_____

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930 E County Line Rd Suite 1 Lakewood,NJ 08701
Phone (732) 363-0364 / Fax (732) 363-0365

Name: _____ Date: _____

Position: _____ Years of Experience: _____

Availability: _____

Your staffing coordinator and Director of Nursing will go over the kind of work we expect for different types of shifts. This applies to LPN's, CHHA's, and CNA's.

CERTIFICATION AND AGREEMENT

I certify that all answers given herein are true and complete. I authorize investigation of any and all statements contained in the application for employment to request and receive from all prior employers within 1 year of the date of this application. I understand that this application is for the sole purpose of determining my eligibility for employment.

I further understand and have been advised that a complete background investigation, as appropriate to my position will be conducted by agents of this company to confirm all information given by me. Said information may include, but not be limited to, Criminal History.

IF YOU HAVE MADE ANY ERRORS ON THIS APPLICATION, PLEASE CORRECT THEM AT THIS TIME.

WAIVER

I understand that the investigation of my background is necessary to be considered for employment with this agency. I agree to hold this agency, its personnel, and all agents HARMLESS with regard to the information received from this background check and its effect on my possible employment, due to any errors in the investigation of my background. I understand that this process is not always exact due to the origin and dissemination of such information. Further, I understand that all information will be treated as CONFIDENTIAL and intended to be used solely for the purpose of determining eligibility for employment by this agency.

Name: _____ Signature: _____ Date: _____
Applicant Applicant Signature

Name: _____ Signature: _____ Date: _____
BP Representative/Title BP Representative Signature

INTELIFI
SCREENING TECHNOLOGY

Pre-Employment Background Check Disclosure & Authorization Form

In connection with my application for employment (including contract for services or volunteer services) or tenancy with

BP Senior Care. These consumer reports (investigative consumer reports in California) may include the following types of information: names and dates of previous employers, salary, work experience, education, accidents, licensure, credit (except California), etc. I further understand that such reports may contain public record information such as, but not limited to: my driving record, workers' compensation claims, judgments, bankruptcy proceedings, criminal records, etc., from federal, state and other agencies which maintain such records. In addition, investigative consumer reports as defined by the federal Fair Credit Reporting Act, gathered from personal interviews with former employers and other past or current associates of mine to gather information regarding my work performance, character, general reputation and personal characteristics may be obtained.

I have the right to make a request to the consumer-reporting agency: INTELIFI, Inc. 8730 Wilshire Blvd, Suite 412, Beverly Hills, California 90211; telephone (888) 409-1819 ("Agency") , upon proper identification, to request the nature and substance of all information in its files on me at the time of my request, including the sources of information and the agency, on our behalf, will provide a complete and accurate disclosure of the nature and scope of the investigation covered by the investigative consumer report(s); and the recipients of any reports on me which the agency has previously furnished within the two year period for employment requests, and one year for other purposes preceding my request (California three years). I hereby consent to your obtaining the above information from the agency. You may view our privacy policy at our website: www.intelifi.com . I hereby authorize procurement of consumer report(s) and investigative consumer report(s).If hired (or contracted), this authorization shall remain on file and shall serve as ongoing authorization for you to procure consumer reports at any time during my employment (or contract) period.

☐ California, Minnesota and Oklahoma Applicants: Check box if you request a copy of your consumer report

Notice to California Residents: You have the right under Section 1786.22 of the California Civil Code to contact the Agency during reasonable hours (9:00 a.m. to 5:00 p.m. (PTZ) Monday through Friday) to obtain all information in your file for your review. You may obtain such information as follows: 1) In person at the Agency's offices, which address is listed above. You can have someone accompany you to the Agency's offices. Agency may require this third party to present reasonable identification. You may be required at the time of such visit to sign an authorization for Agency to disclose to or discuss your information with this third party; 2) By certified mail, if you have previously provided identification in a written request that your file be sent to you or to a third party identified by you; 3) By telephone, if you have previously provided proper identification in writing to Agency; and 4) Agency has trained personnel to explain any information in your file to you and if the file contains any information that is coded, such will be explained to you.

Notice to New York Residents: I acknowledge receiving a copy of Article 23A of the NY Correction Law

I AUTHORIZE, WITHOUT RESERVATION, ANY PARTY OR AGENCY CONTACTED BY THE CONSUMER REPORTING AGENCY TO FURNISH THE ABOVE-MENTIONED INFORMATION. I acknowledge that I have been provided a copy of consumer's rights under the Fair Credit Reporting Act.

Print Name _____ Social Security # _____ Date of Birth _____

Applicant's Signature _____ Date _____ Driver's License # _____ State____

_____ _____

Email (required in order to receive legal notices) Any other names used

_____

Initials

BPSeniorCare

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Lakewood, NJ 08701
Phone (732) 363-0364 / Fax (732) 363-0365

Caregiver Agreement Contract

This is an agreement between BP Senior Care and _____ the employed "Caregiver" working as a _____. The Caregiver may work at various locations and for various clients, as deemed suitable by BP Senior Care. Assignments will be given based on client location, need, and specific criteria requested by client as well as the certification, training, experience, location, availability and other qualifications of the "Caregiver". BP Senior Care agrees to provide this employment opportunity for the "Caregiver" with no guarantee of hours or promise of continued employment. The "Caregiver's" employment status is considered per diem, part time and temporary, as shifts are offered on an as needed basis. The "Caregiver" can be dismissed from a case at any time with or without notice. BP Senior Care requires a "Caregiver" to provide two (2) weeks' notice when leaving a case or the agency's employee.

Please acknowledge the following conditions, policies & requirements for employment by initialing each:

☐ There is no guarantee of hours; work is considered per diem, part time & temporary based on shift and "Caregiver" availability and client/family satisfaction with the caregiver's services. Client/family satisfaction is determined by supervisor evaluated home visits and client/family feedback.

☐ The "Caregiver" is paid bi-weekly through BP Senior Care payroll department after submitting a completed, signed time sheet each week by Monday at 12 noon for the week prior. Time sheet must include client name, address, employee name, dates and hours of service. For every pay period federal and state taxes as well as other required deductions will be deducted from your pay check. It's advised to keep track of each pay period and earnings for your own records to avoid unnecessary confusion. At the end of the year, employed and formerly employed "Caregivers" are issued a W2 for tax purposes.

☐ The "Caregiver" cannot negotiate changes in hours, changes in days, changes in wages, or work privately or through another agency with any BP Senior Care Client for a minimum of 2 years from date services end with a client. If I violate this condition, I agree to pay BP Senior Care liquidated damages upon demand. All changes or negotiations are to be handled through the office staff members and will be in compliance with the client's contract. "Caregivers" are required to communicate all changes, concerns or issues with our office staff.

☐ BP Senior care expects all "Caregivers" to abide by The Rules and Regulations as well as the Policies and Procedures of the company. Manuals with this information are provided and are to be used as guidelines by "Caregivers" in their daily conduct and performance of their duties. The manuals are important; please read carefully and be sure you understand them and address any questions with the supervisory staff.

☐ Uniforms including a name badge and closed toed non-skid shoes, are mandatory while working at all times. An exception may be made upon client request for caregiver to be in "street clothes", however a name badge must still be worn. As a BP Senior Care employed caregiver it is requested for you to wear the selected colors, which are a blue top and blue or white pant (medical scrubs are best). We advise you to wear gloves when administrating personal care to the client and at times when personal protective gear is necessary. Please follow OSHA safety guidelines at all times for the safety of yourself and the client.

☐ Conduct and Professionalism: As an important part of BP Senior Care and at many times the "face" of the Company, the "Caregiver" agrees to promote the Company's image by maintaining the highest level of professional standards. The "Caregiver" agrees to conduct all business affairs with honesty, integrity, discretion, compassion and respect. It is expected that the "Caregiver" will do everything possible, at all times to enhance the reputation of the Company as a group of skilled professionals offering honest, dependable, caring service to our clients and their families.

By signing below the caregiver agrees with the above initialed statements in this contract. Failure to abide by any of BP Senior Care's Policies, Procedures, Rules or Regulations may lead to disciplinary action up to and including termination. BP Senior care has the responsibility to hire, retain and or dismiss caregivers based on training, certification, performance, and feedback from supervisory staff, clients and or family members.

Caregiver's Signature: _____ Date: _____

Authorized Representative: _____ Title: _____ Date: _____

BPSeniorCare

930 E County Line Rd Suite 1
Lakewood, NJ 08701
Phone (732) 363-0364 / Fax (732) 363-0365

EMPLOYEE SALARY AGREEMENT

I_____agree to the following wages, as a BP Senior Care contracted employee.

As a Live in Aide, I agree to be paid the following salary: $ _____ for 24 hour coverage and
$ _____ for Overnight coverage

As a Live out / Hourly Aide, I agree to be paid the following salary: $_____ for hourly coverage and
$ _____ for Overnight Coverage.

As a Driver, I agree to be paid the following salary: $ _____ per hour along with a Mileage Reimbursement of $ _____ / per Mile as well as tolls paid. I understand I will need to provide odometer readings to support mileage and supporting documentation/receipts for toll and/or parking fees submitted.

NOTIFICATION OF UNEMPLOYMENT BENEFITS

BP Senior Care is a licensed temporary employment agency with NJ State. As an agency, we do not guarantee full time employment. The agency may deny employment benefits for the following reasons:

- Refusal of work offered
- Not alerting agency to change of address/phone numbers
- Not returning phone calls regarding work assignments / Not calling the office for an assignment (daily)
- Accepting an assignment and not notifying BP Senior Care that you will not be going to work (No Call No Show)
- Excessive lateness or Misrepresenting time worked on the case
- Lying or stealing from client or employer, stealing cases
- Taking any object or money that belongs to our client; accepting any money or gifts from our clients
- Being under the influence of alcohol or drugs, or smoking at Work
- Refusal to perform assigned duties on a case or unsatisfactory job performance
- Taking another person to work other than employee
- Verbal and/or physical abuse of any client or employee

Not following BP Senior Care's policies and procedures. The agency reserves the right to spot check their employees.

TEMPORARY EMPLOYMENT ACKNOWLEDGEMENT

By signing below I further acknowledge and understand that my employment with BP Senior Care is considered part time and temporary. It is further contingent upon a completed, acceptable background check being run and approved The background check will be done prior to employment and can be run from time to time at the employer's discretion. . If the background report is not approved, you will be terminated immediately.

Notes: _____

_____

Caregiver's Signature: _____ Date: _____
BP Senior Care Authorized Representative: _____ Title: _____ Date: _____

BPSeniorCare
930 E County Line Rd Suite 1 Lakewood, NJ 08701
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Attention Newly Hired Employees

The following BP Senior Care Office Policies must be strictly followed in order to continue working for BP Senior Care:

1. You must be on time for your shifts. This is imperative.
2. If you cannot make a shift and need to call out, you must contact the agency immediately. This must be done a minimum of four hours prior to the start of your shift. Someone is available to answer your calls 24 hours a day. You must speak to someone in person. Make sure you have cell phone numbers for the office staff for after hour call outs.
3. If you do not like the assignment given to you, do not walk out on your shift. Inform us after the completion of the shift, and we will no longer send you to that assignment.
4. If a message is left by BP Senior Care on your phone, it is important to call back as soon as the message is retrieved.
5. A No Call No Show will result in immediate dismissal unless an emergency has arisen and documentation can be provided.
6. A weekly call with availability is mandatory. If BP Senior Care does not receive a call with your availability, we will assume you are not available for work.
7. If there are any changes with your name, address, phone number or email, you must notify us of this immediately.

Please remember that it is imperative to make a good impression with our clients so that they can continually give us work for you.

Attendance, punctuality, reliability and communication with BP Senior Care will be considered. Should I fail to comply with BP Senior Care's policies, my services will no longer be required.

Notice to Caregivers of our clients

Caregivers Responsibilities: We understand the need for flexibility and for customizing care based on each individual client's needs, but the following are the minimum requirements we have for all caregivers that provide services to the client:

- Bathing and dressing (if appropriate)
- Assistance in personal grooming Light housekeeping, laundry
- Meal preparation-appropriate to dietary needs
- Transferring-if necessary
- Provide socialization, hands on engagement
- Provide transportation, if appropriate
- Act in professional manner
- Medication reminders (only)
- Stimulation of client with verbal conversation and memory enhancing activities.
- Shopping and errands with client in variety of appropriate activities

It is extremely important that use of a cell phone should be limited to when a break is taken and not used when giving care to the client. No cell phone use is permitted in common areas of any facility you are working in.

Use of alcohol/drugs is always prohibited, as is permitting friends/family members or other unauthorized visitors on client premise.

Contact Caregiver Agency for: Respite needs, scheduling or Payroll issues and any employment concerns.

I have read the above and agree to the terms as outlined herein

Please Print Name: _____

Applicant's Signature: _____ Date: _____

BP Senior Care Representative Signature: _____ Title: _____ Date: _____

Revised 11/2023

BPSeniorCare

RECEIPT OF HARASSMENT AND WORKPLACE VIOLENCE POLICIES AND PROCEDURES

BP Senior Care, LLC (BP) specific policies regarding Sexual Harassment, Non-Harassment and Workplace Violence are included in this Employee Handbook.

Generally, BP prohibits harassment and any other adverse employment actions of any employee by management, coworker, client, or visitor on the basis or sex, gender, race, color, disability, religion, age, sexual orientation, or any other classification protected by applicable law.

Additionally, BP is strongly committed to providing a safe and violence free workplace. As such, threats, threatening language, or any other acts of aggression or violence made toward or by any BP employees as well as by clients, family members will not be tolerated. Threats include any verbal or physical harassment or abuse, attempts at intimidating or instilling fear in others, menacing gestures, flashing of weapons, stalking, or any other hostile, aggressive, injurious and/or destructive actions undertaken for the purpose of domination or intimidation.

BP will not allow any form of retaliation against individuals, who, in good faith, report allegations of harassment or workplace violence to management, or who cooperate in investigation of such reports in accordance with the respective policy.

All employees of BP are expected to cooperate with the investigatory process.

Reports or complaints made under these policies may be kept confidential, to the extent that confidentiality does not impede BP ability to investigate and respond to the reports or complaints.

PROCEDURE:

- Any employee who feels that he/she has been subjected to conduct which violates any of these policies should immediately report the matter to the BP Office.
- Any employee that is injured in the course of their employment and with relation to these policies must promptly report such injuries to the BP Office and follow the BP procedures for handling all workplace injuries or illnesses.
- If you are unsure of to whom to raise an issue of harassment or workplace violence, or if you have not received a satisfactory response within five (5) business days after reporting any incident of what you perceive to be covered harassment or workplace violence, please promptly notify the Owner.
- In the event of an off-hour complaint (when the company office is closed) an employee may call the office (732) 363-0364 to retrieve the emergency contact numbers on answering recording if not already in possession.
- All employees are expected to cooperate in the investigatory process
- Every report of perceived covered harassment or workplace violence will be fully investigated and corrective action will be taken where appropriate.
- Violation of this policy will result in disciplinary action, up to and including termination.

DECLARATION: I have received, read, and understand my obligations regarding the above mentioned policies. I agreed to abide by these Policies and Procedures.

Employee's Printed Name:_____ Position _____

Employee's Signature: _____ Date: _____

BPSeniorCare
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Mandatory HIPAA Training

"Mission: Confidential"

HIPAA Privacy Rule Compliance Training

Why is it important to keep private information confidential?
Privacy is one of our most important rights. Our customers trust us with their personal information and expect that we will keep it private and confidential. A breakdown in confidentiality can embarrass and hurt both our customer and BP Senior Care.
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) ensures that customers have the right to control who will see their protected, · identifiable health information. Only the customer and the individuals that the customer authorizes have access to their information. There are civil and criminal penalties for violating HIPAA. Key Concepts to Learn:
What is considered Protected Health Information (PHI)?
It is health information (condition, service or payment) with information that may identify an individual. Data elements considered an identifier include:

X	Name	X	Phone/Fax Number	X	Photographs
X	Address	X	E-Mail Address	X	Codes
X	Social Security Number	X	Medical Record Number	X	Anything Else That May Identify the Individual
X	Employer	X	Member/Account Number		
X	Relatives Names	X	Certificate number		
		X	Fingerprints		
X	Date of Birth				

What steps are necessary in order to protect Protected Health Information? Keeping confidential information private is not new to long term care. Our medical code of ethics has always emphasized the importance of confidentiality. Keeping personal information private is central to providing quality care. If our customers do not trust us, they may not communicate important medical information, and changes in their condition may go undetected.

At BP Senior Care, we communicate information in many different ways. Meetings, white boards, reports, medical records, charts, face-to-face and telephone conversations, faxes, written information, and electronic records all help us to communicate.

We communicate customer information through three main mediums: Verbal, Written, and Electronic. It is important to recognize the steps necessary to protect customer information in all three mediums.

Who has the right to access information?
Foremost, the customer and his/her representative always has the right to access their own information (with only very few exceptions). Family and friends can be informed of the customer's health care, if the customer has agreed for them to have access. The customer can always be asked if it is acceptable to share their information with their family. Healthcare workers can access customer's protected health information if they have a "need to know". This means that the information is necessary to provide care. Just follow the simple "need to know" rule. If you need to see customer information to perform -as doctors, nurses, pharmacists, CNA's, and billing clerks do -you are allowed to do so. However, even doctors and nurses don't have the right to look at all the information about every customer. In addition to these rights, our customers can request an amendment, or change to the information that is contained in their medical records. If customers think their record is inaccurate, they can submit proposed amendments for review.

HIPAA Privacy Rule Compliance Training Continued

Our customers have the right to request a list of where their personal information was released. Maintaining accurate details regarding the release of such information is critical to quality care.

What if I overhear or see something I shouldn't?
Sometimes you may overhear information. Not all information is locked up in a file. There is no doubt that you will overhear and see protected health information as you do your work. It is important to keep this information to yourself.

What about the information in the trash can?
Even the trash is private. You might see discarded portions of a chart or financial information in the trash. If you see customer information, in an open trash container, you must tell your supervisor or a supervisor in the area. He or she can get rid of it properly, either into a locked bin or directly into a paper shredder.

What if I see someone violating a customer's privacy?
It is part of your job as an employee at BP Senior Care to help protect our customer's privacy. Employees/ Associates are encouraged to report suspected violations to their supervisor. These reports can even be reported anonymously.

What must we do before release PHI?
Customers have the right to determine who can access their private information. A specific document called an Authorization in necessary before disclosing PHI for any reason beyond treatment, payment, and operations.

As employee, associates, & people involved with long term care, we have an important responsibility to stay informed in order to provide quality health care while respecting and protecting our customer's privacy.

I hereby acknowledge that I have reviewed and understand the HIPPA Privacy Rule.

Employee's Name (printed): _____

Employee's Signature: _____ Position: _____ Date_____

The signed original copy of this receipt will be kept in your personnel file.

HEPATITIS B VACCINE ACCEPTANCE/DECLINATION FORM
BP Senior Care

ACCEPTANCE:

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of being infected by bloodborne pathogens, including Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV). This is to certify that I have been informed about the symptoms and the hazards associated with these viruses, as well as the modes of transmission of bloodborne pathogens. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. In addition, I have received information regarding the Hepatitis B (HBV) vaccine. Based on the training I have received, I am making an informed decision to accept the Hepatitis B (HBV) vaccine.

DECLINATION:

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B 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.

CHECK ONE:

_____ I ACCEPT Hepatitis B vaccine inoculation

_____ I DECLINE Hepatitis B vaccine inoculation

Employee Name (print): _____ Title: _____

Employee Signature: _____ Date: ____/____/_____

Witness Name (print): _____ Title: _____

Witness Signature: _____ Date: ____/____/_____

Rev. _05/2023___

By signing this form, I confirm that I have been in-serviced and have received material on the Conscientious Employee Protection Act “Whistleblower Act”.

Employee Name:_____ Date:_____

Director of HR:_____ Date:_____

By signing this form, I confirm that I have been in-serviced and have received material on the CORPORATE COMPLIANCE & ETHICS POLICY.

Employee Name:_____ Date:_____

Director of HR:_____ Date:_____

By signing this form, I confirm that I have received a copy of BP Senior Care Handbook

Employee Name: _____ Date: _____

Director of HR: _____ Date: _____

REVISED 04/2022

BPSeniorCare

930 E County Line Rd Suite 1
Lakewood, NJ 08701
Phone (732) 363-0364 / Fax (732) 363-0365

UNIFORM & DRESS CODE

The following dress code must be adhered to at all times.

1) Wearing appropriate uniform at all times; except when allowed or stated.
2) Wearing name badge that is visible to clients, staff, etc.
3) Wearing appropriate shoes. No crocs, clogs or open-toes shoes.
4) Non work attire such as hats or head dressings (other than for religious and medical purposes), lanyards, buttons/pins, support bracelets will not be permitted as part of the uniform and/or dress code.
5) Kerchiefs/bandanas are not permitted. Hair should be neat and well-groomed at all times.
6) Protruding jewelry that can pose an infection control issue should be avoided as well.

_____
Print Name

_____
Signature

Revised 7/2019

BPSeniorCare

930 E County Line Rd Suite 1
Lakewood, NJ 08701
Phone (732) 363-0364 / Fax (732) 363-0365

Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____

Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: ☐ $ _____ ☐ _____% or ☐ Entire Paycheck

Type of Account: Checking Savings (Circle One)

Please attach a voided check for each bank account to which funds should be deposited.

BP Senior Care is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee Signature: _____

Date: _____

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)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

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.

Form **8850**
(Rev. March 2016)
Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

▸ **Information about Form 8850 and its separate instructions is at *www.irs.gov/form8850.***

OMB No. 1545-1500

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name _____ Social security number ▸ _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

If you are under age 40, enter your date of birth (month, day, year) _____

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if **any** of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  a. Received SNAP benefits (food stamps) for the past 6 months; **or**
  b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months; **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

7 ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▸ _____ **Date** _____

Please fill in these forms slowly and legibly. *Form Updated 01/01/2020*	**Company Name:** BP Senior Care **Company EIN Number:** 20-1528623

Have you ever **worked for *this* Employer before? Are you a Re-hire?**	Yes___ No___
Are you under age 40?	Yes___ No___
Have you been **unemployed for at least 27 weeks,** and collected Unemployment Insurance?	Yes___ No___
Are you a Veteran of the US Armed Forces? If *yes*: Are you a member of a family that received SNAP (Food Stamps Benefits)? Yes___ No___ Are you entitled to compensation for a service-connected disability? Yes___ No___ Were you discharged from active duty within the last year? Yes___ No___ Were you unemployed for a combined total of 6 months before you were hired? Yes___ No___	Yes___ No___
Have you, or your family, received **SNAP benefits (Food Stamps)** in the **6 months** before you were hired? Or received **SNAP Benefits** for at least a **3-month period**, but you are no longer receiving it? If yes to either question, enter Name of Primary Recipient: _____ And City, State where benefits were received_____	Yes___ No___ Yes___ No___
Are you a member of a family that received **TANF** assistance for at least 18 months before you were hired? Or, did your family stop being eligible for **TANF** assistance within 2 years before being hired, because you reached the maximum time those benefits can be received? If yes to either question, enter Name of Primary Recipient: _____ And City, State where benefits were received_____.	Yes___ No___ Yes___ No___
Did you receive Supplemental Security Income **(SSI Benefits)** for any month, ending within the 60 days, before you were hired?	Yes___ No___
Were you convicted of a **Felony** during the year before you were hired?	Yes___ No___
Were you referred to an employer by • A Vocational Rehab Agency approved by the state? • An Employment Network under the Ticket to Work Program? • The Dept. of Veteran Affairs?	Yes___ No___ Yes___ No___ Yes___ No___

Print Name:	Social Security #:	Date of Birth:
_____	_____ - _____ - _____	_____

By signing this form, I hereby authorize any agency, organization, Social Security Administration, Department of Veterans Affairs, or individuals, to supply verification of information as may be needed to determine tax credit eligibility to my employer, employer representative (TC Services USA, Inc. dba WOTC.com), or the Department of Labor. I also understand that my responses are used, in part or in full, to complete the IRS Form 8850 and any other documents pertaining to the WOTC Program, and that modifications can be made by my employer, or employer representative, in order to enable the verification screening process as required by some states. This information will not in any way affect my employment.

Employment Start Date_____**Starting Wage**_____**Position**_____

Signature_____**Today's Date**_____

WOTC.com
Work Opportunity Tax Credit

Upload To: www.wotc.com | Phone: 212-635-9500 | Fax: 212-994-2718 | Email: support@wotc.com

bp senior care
Home health care &nursing

930 E County Line Rd Suite 1
Lakewood, NJ 08701
Phone (732) 363-0364 / Fax (732) 363-0365

Health Attestation Form

Employee Name: _____

Date of First Case: _____ (first day worked)

Action Completed	**Dates**	**Signature/Title**
☐ Post-Offer Health Assessment	_____	_____
☐ **Initial TB Screening**	_____	_____
☐ IGRA blood test *OR*	_____	_____
☐ 1-step Mantoux Screening	___ /____	_____
OR		
☐ Date of chest x-ray	_____	_____
☐ Date of TB questionnaire	_____	_____
☐ Annual TB Screening Questionnaire	_____	_____
☐ Hepatitis B Vaccine: date accepted/declined	_____	_____
☐ Influenza Vaccine (if warranted)	_____	_____
☐ Periodic Physicals (if required by agency)	_____	_____

Designated Reviewer

I attest that the above information is truthful and correct pursuant to my review of the health records for the above employee.

Name (Print):_____Title:_____

Signature:_____Date:_____

Name (Print):_____ Title:_____

Signature:_____ Date:_____

Name (Print):_____ Title:_____

Signature:_____ Date:_____

ACCREDITED cahc Commission on Accreditation for Home Care

bp senior care
Home health care &nursing

930 E County Line Rd Suite 1
Lakewood, NJ 08701
Phone (732) 363-0364 / Fax (732) 363-0365

Alternate Assessment - TB Screening Questionnaire

Employee Name: _____

This form is completed annually for those employees who have documentation of a negative chest X-ray following a positive Mantoux screening test, and whose medical evaluation and chest X-ray indicate that no further Mantoux screening is required.

Do you experience any of the following:	Yes	No
• bad cough that lasts longer than two (2) weeks	☐	☐
• coughing up sputum (phlegm)	☐	☐
• coughing up blood	☐	☐
• loss of appetite	☐	☐
• weakness/fatigue/tiredness	☐	☐
• night sweats	☐	☐
• unexplained weight loss	☐	☐
• fever	☐	☐
• chills	☐	☐
• chest pain	☐	☐

Have you recently spent time with someone who has infectious tuberculosis? ☐ Yes ☐ No

Foreign born person from or recent traveler to high-prevalence area of TB? ☐ Yes ☐ No

Chest X-Ray with impression findings suggestive of LTBI or past TB? ☐ Yes ☐ No

Have you been told that you have low T4 cell count due to infection? ☐ Yes ☐ No

Are you an organ transplant recipient within last year? ☐ Yes ☐ No

Resident or employee of high-risk congregate setting (LTCF, Hospital) ☐ Yes ☐ No

Were you told in the last year that you may have Immunosuppression due to medication or a chronic disease ☐ Yes ☐ No

Any other complaints? ☐ Yes ☐ No

If yes, explain:_____

ACCREDITED cahc Commission on Accreditation for Home Care

The above health statements are accurate to the best of my knowledge. I have been in-serviced on the signs and symptoms of tuberculosis and been advised to seek medical care if any of the symptoms develop at any time.

Employee Name (print): _____ Title: _____

Employee Signature: _____ Date: ____/____/_____

Nurse Reviewer Recommendation

☐ Refer employee TB/LTBI screening before continuing work.

☐ Refer employee for medical evaluation immediately, before continuing work.

☐ No action to be taken at this time.

RN Name (print): _____ Title: _____

RN Signature: _____ Date: ____/____/_____

Employee Personal Health Self-Assessment

Employee Name _____ Date _____

Overall Health View:

Complete the following statement: "In General, my overall health is … "

a) excellent b) very good c) good d) fair e) poor

Preventative Health:

Have you had a COVID-19 vaccination? Yes / No Complete series? Yes / No

Have you had a flu shot in the last 12 months? Yes / No

Have you been vaccinated for MMR (Measles, Mumps, Rubella) Yes / No Date: _____

Have you been Vaccinated for Hepatitis B? Yes / No Date: _____

Job Requirements and Responsibilities:

Do you feel that you can fulfill the requirements and responsibilities per the job description of the position for which you are applying? Yes / No

Reviewed by:_____ Date: _____