

# Employment Application



Please Print

Premier Healthcare Services is an Equal Opportunity Employer

Date \_\_\_\_\_ Client \_\_\_\_\_

Are you related to this client?  Yes  No If Yes, how? \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

Primary Phone ( ) \_\_\_\_\_ Secondary Phone ( ) \_\_\_\_\_

Email Address \_\_\_\_\_

Present Address \_\_\_\_\_  
No. Street City State Zip

## Personal Information

Name, address and telephone number of person to be notified in case of accident or emergency.

Have you ever applied to work for Premier Healthcare Services, LLC before?  Yes  No If yes, when? \_\_\_\_\_

Are you at least 18 years old?  Yes  No

If hired, can you present evidence of your legal right to work in this country?  Yes  No

Can you perform the essential functions of the position for which you are applying?  Yes  No

Have you ever been convicted of a criminal offense (felony or serious misdemeanor)?  Yes  No

*(do not include if the conviction was for a marijuana-related offense that was more than 2 years ago, or if the disposition involved referral to or participation in a pre or post-trial diversion program.)*

If yes, state the nature of the crime(s), when and where convicted and disposition of the case.

*(Note: No applicant will be denied employment solely on the grounds of conviction of a criminal offense. The nature of the offense, the date of the offense, the surrounding circumstances and the relevance of the offense to the position(s) applied for may, however, be considered.)*

## Employment History

I understand consideration for employment with Premier will be contingent upon the results of reference and criminal background checks. I authorize Premier to investigate all information I provide on this application for employment, including previous employment, experience and educational credentials. I also give Premier permission to contact my former employer(s), all listed references or any other person who can verify the information I provide on this application. I hereby authorize and direct my current and former employers and other contacted persons to respond to any questions pertaining to the information included on this application.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

List below all present and past employment starting with your most recent employer (previous 5 years is sufficient).  
Account for all periods of unemployment. You must complete this section even if attaching a resume.

From _____	To _____	Employer _____	Address _____
Job Title _____	Duties _____	_____	Ending Salary _____
Supervisor _____	Phone _____	Reason for leaving _____	_____

Note: Attach additional page(s) if necessary.

**PLEASE READ EACH PARAGRAPH BELOW. IF YOU DO NOT UNDERSTAND ANY PART OF THE INFORMATION INCLUDED IN EACH PARAGRAPH, PLEASE ASK THE INTERVIEWER BEFORE SIGNING.**

*All employees, contractors and lessees are required to adhere to the Premier Drug & Alcohol Policy. The information provided below is intended to be a brief summary of this policy and is not inclusive. All persons selected for employment with Premier will receive a complete copy of the Drug & Alcohol policy. Our complete policy is also available for review upon request in our Human Resources Department.*

I understand that Premier maintains a Drug & Alcohol-free workplace and may require a drug & alcohol screening test as a condition of employment for specific job classifications. If I do not complete the pre-employment drug & alcohol testing within 24 hours of being offered a position for which pre-employment drug & alcohol testing is required or if I test positive, refuse to test or submit an adulterated specimen, I understand I will not be considered for employment.

I further understand that if I am employed by Premier, I may be required to submit to random drug testing if I am employed in a safety sensitive position. If I sustain a work related injury, I may be required to submit to post-accident drug testing if the circumstances surrounding the cause of such accident indicate that I was at fault or if it is unclear if I was at fault. Premier may also conduct reasonable suspicion drug & alcohol testing during the course of my employment. Testing positive, refusing to test within the designated time period or submitting an adulterated specimen for any random, reasonable suspicion or post-accident drug & alcohol screening during my employment will be considered a voluntary resignation of such employment.

**I understand that Premier abides by an employment-at-will policy, which means either the company or the employee may terminate the employment relationship at anytime, for any reason or for no reason, with or without notice. Nothing contained in this employment application, any employee handbook or conveyed to me during an interview is intended to create an employment contract, implicit or implied. I also understand and agree that any future changes in my title, duties, compensation, working conditions, or company benefits, policies and/or procedures will not alter this at-will agreement. This at will agreement can only be changed or modified in writing by the President of Premier Healthcare Services.**

If I am applying for a position for which driving a vehicle is a mandatory job duty, I am required to possess a current and valid driver's license and I agree to provide Premier with a certified copy of my driving record. I also understand that any offer of employment is contingent upon my overall driving record, and my ability to be covered by the company's vehicle insurance policy.

I certify that I completed this application for employment by myself and that all of the information provided herein is true. I understand that any omission, misstatement or inclusion of false information on this application or any documents used to secure employment with Premier shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

I understand that this application is considered current for three months. If I wish to be considered for employment after this 3-month period, I must complete and submit a new employment application.

My signature below certifies that I have read and fully understand the information included on this application and agree to the terms and conditions outlined in this document.

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

Date \_\_\_\_\_

Premier is an Equal Opportunity Employer. All qualified applicants will receive consideration without regard to race, color, religion, gender, gender identity, national origin, age, disability, veteran status or any other status protected under local, state or federal law.



**TO:** All Care Providers

**RE:** Form I-9 Supporting Documentation

Dear Care Provider:

Please be sure to submit a **legible copy** of your **Driver's License** and **Social Security Card** along with your application.

A passport will also satisfy the requirements of the Federal Government to verify your identity.

If you would like to come to the office to make copies of the necessary documents, please feel free to do so.

We are open 8a-5pm Monday through Friday.

# Form W-4 (2010)

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

**Exemption from withholding.** If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2010 expires February 16, 2011. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** You cannot claim exemption from withholding if (a) your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on his or her tax return.

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

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

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

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax

payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

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

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2010. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

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

<b>A</b>	Enter "1" for <b>yourself</b> if no one else can claim you as a dependent . . . . .	<b>A</b> _____			
<b>B</b>	Enter "1" if: <table border="0" style="display: inline-table; vertical-align: middle;"> <tr> <td style="font-size: 3em; vertical-align: middle;">{</td> <td style="padding: 0 10px;"> <ul style="list-style-type: none"> <li>• You are single and have only one job; or</li> <li>• You are married, have only one job, and your spouse does not work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul> </td> <td style="font-size: 3em; vertical-align: middle;">}</td> </tr> </table>	{	<ul style="list-style-type: none"> <li>• You are single and have only one job; or</li> <li>• You are married, have only one job, and your spouse does not work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul>	}	<b>B</b> _____
{	<ul style="list-style-type: none"> <li>• You are single and have only one job; or</li> <li>• You are married, have only one job, and your spouse does not work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul>	}			
<b>C</b>	Enter "1" for your <b>spouse</b> . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . .	<b>C</b> _____			
<b>D</b>	Enter number of <b>dependents</b> (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b> _____			
<b>E</b>	Enter "1" if you will file as <b>head of household</b> on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b> _____			
<b>F</b>	Enter "1" if you have at least \$1,800 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . .	<b>F</b> _____			
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> <li>• If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then <b>less</b> "1" if you have three or more eligible children.</li> <li>• If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" <b>additional</b> if you have six or more eligible children.</li> </ul>	<b>G</b> _____			
<b>H</b>	Add lines A through G and enter total here. ( <b>Note.</b> This may be different from the number of exemptions you claim on your tax return.) ▶	<b>H</b> _____			
	For accuracy, <b>complete all worksheets that apply.</b> <table border="0" style="display: inline-table; vertical-align: middle;"> <tr> <td style="font-size: 3em; vertical-align: middle;">{</td> <td style="padding: 0 10px;"> <ul style="list-style-type: none"> <li>• If you plan to <b>itemize or claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.</li> <li>• If you have <b>more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$18,000 (\$32,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.</li> <li>• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.</li> </ul> </td> <td style="font-size: 3em; vertical-align: middle;">}</td> </tr> </table>	{	<ul style="list-style-type: none"> <li>• If you plan to <b>itemize or claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.</li> <li>• If you have <b>more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$18,000 (\$32,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.</li> <li>• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.</li> </ul>	}	
{	<ul style="list-style-type: none"> <li>• If you plan to <b>itemize or claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.</li> <li>• If you have <b>more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$18,000 (\$32,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.</li> <li>• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.</li> </ul>	}			

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

Form <b>W-4</b> Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ <b>Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</b></p>	OMB No. 1545-0074  <div style="font-size: 2em; font-weight: bold; margin: 0;">2010</div>
1 Type or print your first name and middle initial.	Last name	2 Your social security number
Home address (number and street or rural route)	3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note.</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>	
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	6 \$	
7 I claim exemption from withholding for 2010, and I certify that I meet <b>both</b> of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability <b>and</b></li> <li>• This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability.</li> </ul> If you meet both conditions, write "Exempt" here . . . . . ▶		7
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (Form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

### Deductions and Adjustments Worksheet

**Note.** Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

- 1** Enter an estimate of your 2010 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions . . . . . **1** \$ \_\_\_\_\_
- 2** Enter: 

{	\$11,400 if married filing jointly or qualifying widow(er)	}	. . . . .	<b>2</b>	\$ _____
	\$8,400 if head of household				
	\$5,700 if single or married filing separately				
- 3** **Subtract** line 2 from line 1. If zero or less, enter “-0-” . . . . . **3** \$ \_\_\_\_\_
- 4** Enter an estimate of your 2010 adjustments to income and any additional standard deduction. (Pub. 919) . . . . . **4** \$ \_\_\_\_\_
- 5** **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 6* in Pub. 919.) . . . . . **5** \$ \_\_\_\_\_
- 6** Enter an estimate of your 2010 nonwage income (such as dividends or interest) . . . . . **6** \$ \_\_\_\_\_
- 7** **Subtract** line 6 from line 5. If zero or less, enter “-0-” . . . . . **7** \$ \_\_\_\_\_
- 8** **Divide** the amount on line 7 by \$3,650 and enter the result here. Drop any fraction . . . . . **8** \_\_\_\_\_
- 9** Enter the number from the **Personal Allowances Worksheet**, line H, page 1 . . . . . **9** \_\_\_\_\_
- 10** **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 **10** \_\_\_\_\_

### Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

**Note.** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1** Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) **1** \_\_\_\_\_
- 2** Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than “3.” . . . . . **2** \_\_\_\_\_
- 3** If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “-0-”) and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . **3** \_\_\_\_\_

**Note.** If line 1 is **less than** line 2, enter “-0-” on Form W-4, line 5, page 1. Complete lines 4–9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

- 4** Enter the number from line 2 of this worksheet . . . . . **4** \_\_\_\_\_
- 5** Enter the number from line 1 of this worksheet . . . . . **5** \_\_\_\_\_
- 6** **Subtract** line 5 from line 4 . . . . . **6** \_\_\_\_\_
- 7** Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . **7** \$ \_\_\_\_\_
- 8** **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . . . **8** \$ \_\_\_\_\_
- 9** Divide line 8 by the number of pay periods remaining in 2010. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2009. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . **9** \$ \_\_\_\_\_

**Table 1**

**Table 2**

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$7,000 -	0	\$0 - \$6,000 -	0	\$0 - \$65,000	\$550	\$0 - \$35,000	\$550
7,001 - 10,000 -	1	6,001 - 12,000 -	1	65,001 - 120,000	910	35,001 - 90,000	910
10,001 - 16,000 -	2	12,001 - 19,000 -	2	120,001 - 185,000	1,020	90,001 - 165,000	1,020
16,001 - 22,000 -	3	19,001 - 26,000 -	3	185,001 - 330,000	1,200	165,001 - 370,000	1,200
22,001 - 27,000 -	4	26,001 - 35,000 -	4	330,001 and over	1,280	370,001 and over	1,280
27,001 - 35,000 -	5	35,001 - 50,000 -	5				
35,001 - 44,000 -	6	50,001 - 65,000 -	6				
44,001 - 50,000 -	7	65,001 - 80,000 -	7				
50,001 - 55,000 -	8	80,001 - 90,000 -	8				
55,001 - 65,000 -	9	90,001 -120,000 -	9				
65,001 - 72,000 -	10	120,001 and over	10				
72,001 - 85,000 -	11						
85,001 -105,000 -	12						
105,001 -115,000 -	13						
115,001 -130,000 -	14						
130,001 - and over	15						

**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 who claims no withholding allowances; 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 using it 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.

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

▶ See separate instructions.

**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 \_\_\_\_\_

Telephone number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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

- 1  Check here if you are completing this form **before** August 28, 2007, and you lived in the area impacted by Hurricane Katrina on August 28, 2005. If so, please enter the address, including county or parish and state where you lived at that time.  
\_\_\_\_\_
- 2  Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 3  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 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 food stamps for the past 6 months, **or**
    - b Received 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.
- 4  Check here if you are a veteran entitled to compensation for a service-connected disability **and**, during the past year, you were:
- Discharged or released from active duty in the U.S. Armed Forces, **or**
  - Unemployed for a period or periods totaling at least 6 months.
- 5  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.

### 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

**For Employer's Use Only**

Employer's name Premier Healthcare Services, LLC Telephone no. ( 213 ) 327 - 1177 EIN ▶ 20 : 4078036

Street address 707 Wilshire Blvd, Suite 4350

City or town, state, and ZIP code Los Angeles, CA 90017

Person to contact, if different from above U.C. Consultants Telephone no. ( 615 ) 352 - 6590

Street address 223 Oceola Avenue

City or town, state, and ZIP code Nashville, Tennessee 37209

If, based on the individual's age and home address, he or she is a member of group 4 or 6 (as described under Members of Targeted Groups in the separate instructions), enter that group number (4 or 6) . . . . . ▶ \_\_\_\_\_

Date applicant: Gave information \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Was offered job \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Was hired \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Started job \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Complete Only If Box 1 on Page 1 is Checked**

State and county or parish of job \_\_\_\_\_

Check if the individual was not your employee on August 28, 2005, and this is the first time the employee has been hired by you since August 28, 2005.

Under penalties of perjury, I declare that the applicant completed this form on or before the day a job was offered to the applicant and that the information I have furnished is, to the best of my knowledge, true, correct, and complete. Based on the information the job applicant furnished on page 1, I believe the individual is a member of a targeted group. I hereby request a certification that the individual is a member of a targeted group.

Employer's signature ▶ \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Privacy Act and Paperwork Reduction Act Notice**

Section references are to the Internal Revenue Code.

Section 51(d)(13) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's federal tax return. Completion of this form is voluntary and may assist members of targeted groups in securing employment. Routine uses of this form include giving it to the state workforce agency (SWA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group. This form may also be given to the Internal Revenue Service for administration of the Internal Revenue laws, to the Department of Justice for civil and

criminal litigation, to the Department of Labor for oversight of the certifications performed by the SWA, and to cities, states, and the District of Columbia for use in administering their tax laws. 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 section 6103.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:  
**Recordkeeping** . . . . . 5 hrs., 30 min.  
**Learning about the law or the form** . . . . . 24 min.  
**Preparing and sending this form to the SWA** . . . . . 30 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6406, Washington, DC 20224.

Do not send this form to this address. Instead, see *When and Where To File* in the separate instructions.



**REPORTING OF CHILD, ELDER, DEPENDENT ADULT ABUSE  
AND DOMESTIC VIOLENCE**

California law requires the reporting of incidents of child, elder, dependent adult abuse and/or domestic violence that comes to your attention in your professional capacity. Please read the statements below and sign in the space provided to acknowledge that you will comply with the reporting requirements. If you have questions, or need assistance with this requirement, please notify your supervisor. Additional information regarding the codes summarized below is also available from your supervisor.

Section 15630 of the Welfare and Institutions Code: Any elder or dependent adult care custodian, health practitioner, or employee of a county adult protective services agency or a local law enforcement agency, who is his or her professional capacity or within the scope of his or her employment, either has observed an incident that reasonably appears to be physical abuse, has observed a physical injury where the nature of the injury, it's location on the body, or the repetition of the injury, clearly indicates that physical abuse has occurred, or is told by an elder or dependent adult that he or she ahs experienced behavior constitution physical abuse, shall report the known or suspected instance of physical abuse either to the long-term care ombudsman coordinator or to a local law endorsement agency when the physical abuse is alleged to have occurred in the long-term care facility or to either the county adult protective services agency or to a local law enforcement agency when the physical abuse is alleged to -- have occurred anywhere else, immediately or as soon as possible by telephone, and shall prepare and send a written report thereof within two working days.

Section 11166.5 of the Penal Code: This code requires any child care custodian, health practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

Section 11160 and 11163 of the Penal Code: This code requires health care workers to report know or suspected cases of a wound or injury resulting from domestic violence or spousal abuse. Such cases must be reported immediately by telephone (or as soon as practically possible) to the local law enforcement agency, followed by a written report to the local law enforcement within two working days.

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

EMPLOYEE SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PREMIER REPRESENTATIVE: \_\_\_\_\_

DATE: \_\_\_\_\_



**CONFIDENTIALITY**

Premier Healthcare Services considers all client medical and financial information confidential. Premier Healthcare Services acknowledges patients rights, falling within the law, to ensure confidentiality and informational privacy.

Premier Healthcare Services acknowledges that all personnel files and information therein shall be considered as confidential and will not be disclosed.

Premier Healthcare Services acknowledges that all pay rates are considered confidential information and are not to be discussed, particularly when on an assignment.

Unauthorized, indiscriminate disclosure, use of review of personal information, medical or otherwise, is forbidden.

Violations of confidentiality may result in termination.

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

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PHS STAFFING REPRESENTATIVE: \_\_\_\_\_ DATE: \_\_\_\_\_



**Premier Respite Care Guidelines**  
*(Please read and initial each line)*

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

\_\_\_\_\_ I must submit my timecards within 60 days of the date services were performed to receive payment.

\_\_\_\_\_ I understand that Respite care is to be provided in the consumer's residence.

\_\_\_\_\_ I understand that transporting Regional Center consumers is not permitted.

\_\_\_\_\_ I understand that I am to be compensated for the amount of hours authorized by the Regional Center for my client(s). Any additional hours are not billable to Premier and/or the Regional Center.

\_\_\_\_\_ I understand that I can call Premier at any time to verify the amount of hours I can bill for my client(s).

\_\_\_\_\_ I understand that my responsibilities as a caregiver include such tasks as non-medical care, attending to basic self-help needs, continuation of usual daily routines, and protecting the consumer's safety in the absence of family members.

\_\_\_\_\_ I understand that I am not to provide care to siblings/other children in the household not authorized for respite care.

\_\_\_\_\_ I understand that I am not allowed to perform medical tasks or dispense medications to the Regional Center consumer.

\_\_\_\_\_ I understand I am not allowed to bring or be visited by any person while providing Respite care.

\_\_\_\_\_ I understand that housekeeping is outside the scope of Respite care and is not permitted.

\_\_\_\_\_ I understand that attending Doctor and/or Therapy appointments with consumer is outside the scope of Respite care and is not permitted.

\_\_\_\_\_ I understand that I must report any injury to myself or to the consumer while I am on duty to Premier within 6 hours of its occurrence.

\_\_\_\_\_ I have received and read the Premier Employee Safety Guidelines.

\_\_\_\_\_ I have received and read the Reporting of Incidents of Child, Elder, Dependent Adult Abuse and/or Domestic Violence Policy.





**JOB TITLE:** Care Provider

**REPORTS TO:** General Manager

**JOB SUMMARY:** The Care Provider is responsible for providing temporary non-medical care to the consumer.

DUTIES AND RESPONSIBILITIES:

- Providing temporary, non-medical care and supervision in the consumer's home
- Temporarily relieve family members of the demanding responsibility of caring for the consumer
- Attend to the daily basic self-help needs of the consumer such as socialization, interaction and continuation of daily activities that a family member would ordinarily perform
- Provide appropriate care and supervision to protect the consumer's safety in the absence of family members

I have received, read and understand the Position Description above.

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

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PHS STAFFING REPRESENTATIVE: \_\_\_\_\_ DATE: \_\_\_\_\_