For Office Use Only
QB-_____ W4-_____
PC/DD-_____ ID#-

Name _____ Date of Hire _____

Copies of:

_____ Driver's License/Picture ID

_____ Social Security Card

_____ Certification (if applicable)

_____ Auto Insurance/Waiver

_____ CPR Card

_____ TB Skin Test

_____ Drug Test

_____ Direct Deposit/Pay Card

_____ Employee Handbook Signer

_____ Name Badge

MERCY HOME CARE, LLC
Non-Medical Aide Employee Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate: _____

DOB: _____ SS#: _____

Drivers License #: _____ exp. date _____

Personal Doctor: _____ Phone: _____

Name of Spouse/Significant Other: _____

Phone #: _____

Additional Emergency Contact: _____

Phone #: _____

Are You Bilingual? _____

Language Accommodation Needed? _____

Sign Language? _____

Related to Client? _____

500518

K-4
(Rev. 11-16)

KANSAS
EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Use the following instructions to accurately complete your K-4 form, then detach the lower portion and give it to your employer. For assistance, call the Kansas Department of Revenue at 785-368-8222.

Purpose of the K-4 form: A completed withholding allowance certificate will let your employer know how much *Kansas* income tax should be withheld from your pay on income you earn from Kansas sources. Because your tax situation may change, you may want to re-figure your withholding each year.

Exemption from Kansas withholding: To qualify for exempt status you must verify with the Kansas Department of Revenue that: 1) last year you had the right to a refund of **all** STATE income tax withheld because you had **no** tax liability; and 2) this year you will receive a full refund of **all** STATE income tax withheld because you will have **no** tax liability.

Basic Instructions: If you are not exempt, complete the **Personal Allowance Worksheet** that follows. The total on line F should **not** exceed the total exemptions you claim under "Exemptions and Dependents" on your Kansas income tax return.
NOTE: *Your status of "Single" or "Joint" may differ from your status claimed on your federal Form W-4).*

Using the information from your **Personal Allowance Worksheet**, complete the **K-4** form below, sign it and provide it to your employer. If your employer does not receive a K-4 form from you, they must withhold Kansas income tax from your wages without exemption at the "Single" allowance rate.

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 cost of keeping up a home for yourself and for your dependent(s).**

Non-wage income: If you have a large amount of non-wage Kansas source income, such as interest or dividends, consider making Kansas estimated tax payments on Form K-40ES. Without these payments, you may owe additional Kansas tax when you file your state income tax return.

Personal Allowance Worksheet (Keep for your records)

A Allowance Rate: If you are a single filer mark "Single"
If you are married and your spouse has income mark "Single"
If you are married and your spouse does not work mark "Joint"

A ☐ Single ☐ Joint

B Enter "0" or "1" if you are married or single and no one else can claim you as a dependent (entering "0" may help you avoid having too little tax withheld) ..... B

C Enter "0" or "1" if you are married and only have one job, and your spouse does not work (entering "0" may help you avoid having too little tax withheld) C

D Enter "2" if you will file head of household on your tax return (see conditions under *Head of household* above) ..... D

E Enter the number of dependents you will claim on your tax return. **Do not** claim yourself or your spouse or dependents that your spouse has already claimed on their form K-4 ..... E

F **Add lines B through E** and enter the total here ..... F

▼ Cut here and give the lower portion to your employer. Keep the top portion for your records. ▼

Kansas Employee's Withholding Allowance Certificate

Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the Kansas Department of Revenue. Your employer may be required to send a copy of this form to the Department of Revenue.

1 Print your First Name and Middle Initial | Last Name | 2 Social Security Number

Mailing address | 3 Allowance Rate
Mark the allowance rate selected in Line A above.
☐ Single ☐ Joint

4 Total number of allowances you are claiming (from Line F above) 4

5 Enter any additional amount you want withheld from each paycheck (this is optional) ..... 5 $

6 I claim exemption from withholding. (You must meet the conditions explained in the "Exemption from withholding" instructions above.) If you meet the conditions above, write "Exempt" on this line 6
Note: The Kansas Department of Revenue will receive your federal W-2 forms for all years claimed *Exempt*.

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.

SIGN HERE ▶ Date

7 Employer's Name and Address | 8 EIN (Employer ID Number)

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

2020

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 widow(er))
☐ Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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

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 most accurate withholding for this step (and Steps 3–4); or

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

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

Add the amounts above and enter the total here . . . . . 3 $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), 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 2020 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 16, 2021.

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

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

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

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

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

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

Specific Instructions

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

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

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

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

CAUTION ***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. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). 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:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . 2 $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1. 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 or 1040-SR)). See Pub. 505 for more information 4 $ _____

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

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

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	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

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	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,760	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,380	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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

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

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

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

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐-☐☐-☐☐☐☐		

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

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

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number):

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy):
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

QR Code - Section 1
Do Not Write In This Space

1. Alien Registration Number/USCIS Number:

OR

2. Form I-94 Admission Number:

OR

3. Foreign Passport Number:

Country of Issuance:

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

Employer Completes Next Page

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

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

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

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A
Documents that Establish Both Identity and Employment Authorization

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:
   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 alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI

OR

LIST B
Documents that Establish Identity

1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor, or hospital record
12. Day-care or nursery school record

AND

LIST C
Documents that Establish Employment Authorization

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. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Native American tribal document
5. U.S. Citizen ID Card (Form I-197)
6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Health Occupations Credentialing
1000 SW Jackson, Suite 330, Topeka, KS 66612-1365

CRIMINAL RECORD CHECK REQUEST FORM

Facility Name: Mercy Home Care, LLC
Address: 822 N. Andover Rd.
Zip Code: 67002

Facility ID#: A-008011
City: Andover State: Kansas

Applicant Information: ALL REQUESTED INFORMATION MUST BE PROVIDED or the form will not be processed.

Last Name: First Name: Middle Name: Suffix (Jr, Sr, etc)

Other Names Ever Used:

Last Name: First Name: Middle Name: Suffix (Jr, Sr, etc)

Last Name:** First Name: Middle Name: Suffix (Jr, Sr, etc)

**List additional names on back. Check here if more on back.

Social Security Number Date of Birth Sex Race

One of the following must be selected
A – Asian or Pacific Islander
B – Black
I – Native American/Alaskan Native
W – White

Address Post Office Box # (if applicable)

City State County Zip

Home Phone Work Phone

Certificate # (if applicable)

Activities Staff	ACS	Food Service Worker	FSW	Medical Records Staff	MRS
Administrator	ADM	Home Health Aide	HHA	Operator	OPR
Business and Administrative	BAS	Home Health Aide Trainee	HHT	Paid Driver	DRV
Certified, Medication Aide	CMA	Housekeeping	HSK	Personnel Staff	PER
Certified Nurse Aide	CNA	Human Resources Staff	HRS	Restorative Aide	RSA
Nurse Aide Trainee	NAT	Laundry Workers	LDW	Social Service Designee	SSD
Chaplain	CHN	Maintenance Worker	MTW	Volunteer Coordinator	VLC
Clerical Staff	CLS	Marketing Staff	MKT	Wellness Staff	WEL

EMPLOYMENT VERIFICATION

I certify the certified nurse/medication aide/home health aide named above is employed by me to perform at least 8 hours of nursing or nursing related services.

Agency Representative Title Date

STATE OF KANSAS
Department for Children & Families
Office of Background Investigations

ADULT ABUSE, NEGLECT, EXPLOITATION CENTRAL REGISTRY RELEASE OF INFORMATION

OBI 10400
REV 2/21

I, _____, give permission for the release of information concerning
(PRINT Full Name)

myself in the Adult Abuse, Neglect, Exploitation Central Registry to:

Contact Person(s)* Becky Waldschmidt **Phone** 316-733-9400

Agency name Mercy Home Care, LLC

Agency mailing address PO Box 580, Andover, KS 67002

Email address: Will return via Encrypted email unless marked otherwise bwaldschmidt@mercyhomecare.com

Maiden Name and/or Other Names Known By: _____
(PRINT ONLY)

Address: _____
Street **City** **State** **Zip Code**

DOB: _____ **SS#:** _____ ☐ Male ☐ Female
(mm/dd/yyyy) **(mark one)**

I understand that all information released will be for the exclusive and confidential use of the above named organization/person. I have read and understand this form and information provided is true and correct to the best of my knowledge.

I give permission for the release of any information concerning myself in the Adult Abuse, Neglect, Exploitation Central Registry each year while I am employed or associated with the above agency. ☐ **Yes** ☐ **No**

Signature: _____ **Date:** ____/____/____
(An Ink Signature or a Verified E-Signature is Required for Processing) **(mm/dd/yyyy)**

RETURN TO:

DCF.APSRegistry@KS.GOV
or
Adult Abuse Registry
555 S. Kansas Ave
Topeka, Kansas 66603-3444

(Please allow 3-5 days for processing email requests and an additional 5-7 days if returning by US Postal Service)

For Official Use Only: Mark in this area if PROHIBITED	For Official Use Only: Mark in this area if CLEARED

Kansas Department for Children and Families
Strong Families Make a Strong Kansas

KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES
Child Abuse and Neglect Central Registry
P.O. Box 2637 • Topeka, KS 66601 • DCF.CentralRegistry@ks.gov

Release of Information

Complete form by printing legibly in ink. Fee of $10.00 per Release of Information form may be required prior to processing.

All releases and fees are to be sent to the address or email listed above (see below for specifics)

CONFIDENTIALITY: ***Kansas Department for Children and Family records are confidential. No individual, association, partnership, corporation, or other entity shall willfully or knowingly disclose, permit, or encourage disclosure of the contents of records or reports in violation of the confidentiality requirements of K.S.A. 38-2209. Violation of this statute is a class A nonperson misdemeanor and the court may impose a civil penalty of up to $1,000.***

Contact Person: Becky Waldschmidt
Phone #: (316) 733-9400
Email: bwaldschmidt@mercyhomecare.com

Agency/Org.: Mercy Home Care, LLC
Address: PO Box 580
City/State/Zip: Andover, KS 67002

Return Results by: ☒ Encrypted email (list if different than above): _____ ☐ Postal Mail

Payment/Account Information (check box which applies)

☐ *Fee included*	$10 per request. Check, Money Order (payable to DCF) or cash. ***Postal mail only.***	
☐ *Online Payment**	www.dcf.ks.gov – 'Online DCF Payments' bottom of page. Payment Portal. Submit receipt with ROI form(s).	
☐ *Pre-Pay Account**	Agency/Org. has Pre-Pay Account.	FEIN:
☐ *Mentoring Account**	As listed in the Kansas Mentors' Partner Directory. http://mentorkansas.org/find-a-Program	
☐ *Exempt**	No fee for State government agencies (Sub-contracting agencies not included)	

*Release of Information forms may be submitted via email to DCF.CentralRegistry@ks.gov

PLICANT: *Instructions: PRINT CLEARLY. All requested information is required for processing. Incomplete or illegible information will result in processing delays for the Release of Information. Use 'N/A' rather than leaving a space blank.*

FIRST, MIDDLE, LAST NAME:

I give permission for the release of any of my information in the Child Abuse/Neglect Central Registry to the contact listed above. I understand the information released is for their exclusive and confidential use: ☐ *Yes* ☐ *No*

This organization/person/agency may check my information each year I am employed or associated with them: ☐ *Yes* ☐ *No*

OTHER NAMES USED: (Any/all aliases, married, maiden, nicknames, etc. 'N/A' if none used.):

DATE OF BIRTH: **RACE:**

SOCIAL SECURITY #: **GENDER:** ☐ *Male* ☐ *Female*

CURRENT ADDRESS:

CITY, STATE, ZIP:

PHONE: **EMAIL:**

SIGNATURE: **DATE:**

DCF ONLY: **MATCH** **CLEARED**

This applicant is listed in the Child Abuse/Neglect Central Registry.

Per KSA 65-504 and 65-516 this person prohibited from working, residing, or volunteering in a licensed child care home or facility.

(see attached document for more info.)

MERCY HOME CARE, LLC
Medication Statement

To be completed only if drug screen results are positive.

Please list any and all routine or PRN medications, either prescription or over the counter that have been taken in the last 30 days.

Please include all items such as aspirin, birth control pills, cough syrup, etc. Be prepared to show prescriptions for the items listed that are considered controlled drugs.

1._____

2._____

3._____

4._____

5._____

_____ _____
Employee Date

_____ _____
Agency Representative Date

MERCY HOME CARE, LLC
Drug Screening Policy

Anyone being considered for employment will be required to consent to a substance abuse screening (drug test). The results of the screen will be evaluated when determining eligibility. Failure to pass the screen or failure to submit to the screen as directed will terminate consideration of your application.

After employment, drug testing for controlled substances or alcohol may be done for cause or at random at any time.

_____ _____
Employee Date

Statement of chain of custody:

I, _____, certify that my specimen never left my sight from the time of collection, through the end results of testing and reporting. I certify that the results recorded here are the results I observed and are documented correctly.

Results:

Circle one in each category:

Amphetamine	positive	negative
Barbiturates	positive	negative
Benzodiazepines	positive	negative
Cocaine	positive	negative
Marijuana	positive	negative
Methadone	positive	negative
Methamphetamine	positive	negative
Morphine	positive	negative
PCP	positive	negative

_____ _____
Agency Representative Date

_____ _____
Employee Date

MERCY HOME CARE, LLC
Non-Medical Attendant Job Description

Title: NON-MEDICAL ATTENDANT

Definition:

The non-medical attendant is responsible for supportive services, which are required to provide and maintain normal environmental and emotional comfort.

Function:

1. Knows the philosophy, purpose, policies/standards of the Agency and is guided by them in providing care.
2. Provides services as instructed by the nurse who supervises the client.
   a. Help with personal care, dressing, undressing (no hands on assistance, i.e. no lifting, bathing, supporting in transfer or ambulating).
   b. Bed making, linen change.
   c. Reminding to use toilet, take medicine, eat.
   d. Meal preparation.
   e. Light housekeeping, dusting, dishes, cleaning bathroom, kitchen, emptying trash, obtaining mail, doing laundry.
   f. Errands such as grocery shopping, etc.
3. Reports to office any changes in client's circumstances or condition.

Qualifications:

1. Emotional/mental stability.
2. Good personal hygiene.
3. The ability to carry out instructions.
4. Considerate approach to others.
5. Personal or business references which indicate responsibility, accountability, and good judgment.

_____ Employee

_____ Agency Representative

MERCY HOME CARE, LLC
Non-Medical Aide Employee Contract

Upon accepting employment with Mercy Home Care, LLC (hereafter referred to as the Agency), I acknowledge and consent to the following terms:

1. I am not guaranteed a specific number of hours. This is termed casual employment.

2. Clients are accepted for care through the Agency.

3. The Agency provides Home Health Aide, Homemaker, and Non-Medical Attendant

4. I am required to know and follow all Agency policies, which apply to me.

5. I am required to participate in, and follow the plans of care for my clients as they are initially developed and as they are modified.

6. When accepting assignment of a client for my service I am required to follow the Agency Schedule for care and to submit the appropriate documentation, i.e. time sheets, etc.

7. I will be paid as a casual employee. I will receive payment for assignments at a rate of _____per hour. I am required to submit properly completed documentation before receiving payment for services.

8. There is no reimbursement for travel.

9. I am not allowed to take an agency directed client in my automobile.

10. When I am paid for my services, I will have all taxes deducted by the Agency. These deductions will be recorded and submitted to me at the year-end for filing my personal tax return. They will be reported on my W-2.

11. I must make arrangements for making up hours that fall on a holiday if able to. Homemaker services will generally not be provided on holidays unless approved by the Agency.

12. I must work every other weekend if my clients receive weekend care.

13. Routine scheduled days off are not guaranteed.

14. I must call and speak to the scheduler to report a call off. If after office hours, and on weekends, contact must be made with the on-call staff through the office phone number.

I understand that Kansas law supports employment at will. I may be relieved of my assigned duties at any time, particularly for absence (even one time per month is excessive) or other noncompliance with Agency policy.

Employee _____ Date _____

Agency Representative _____ Date _____

MERCY HOME CARE, LLC
Confidentiality Statement

The law which applies to physicians regarding the completely confidential nature of client information is a rule which applies to all Mercy Home Care, LLC employees. This includes all Home Care professionals.

Except where necessary in the regular course of business, the discussion in any form of any client information of a personal nature, medical or otherwise, obtained in the regular course of your employment is strictly forbidden.

Any violation of this professional rule shall constitute grounds for severe disciplinary action, including possible discharge.

I have read and understand the contents of this statement.

_____ _____

Employee Date

_____ _____

Agency Representative Date

MERCY HOME CARE, LLC

MANTOUX (TB) TEST

Employee Name: _____

History of prior reaction to Mantoux Test: _____ YES _____ NO
If yes, was the screening for Signs and Symptoms of Tuberculosis completed:
_____YES_____NO

If positive, date of last chest x-ray: _____

I hereby authorize Mercy Home Care, LLC to administer the tuberculin Mantoux test and release Mercy Home Care, LLC and its personnel of all liability in connection therewith, and acknowledge above information to be correct.

_____ _____
Employee Date

ADMINISTRATION
Name of Test Used: Tuberculin PPD
Route: Intracutaneous
Dosage: 5 tuberculin units (0.1 cc)
Date_____
Site_____
Expiration Date_____
Lot#_____
Manufacturer_____

Administered By:_____

INTERPRETATION (Read in 48-72 hours)

Date_____ Time_____

Area of Induration_____ (measure in millimeters)

_____Significant-induration 10mm or more

_____Non-significant-induration less than 10mm

Read By_____

MERCY HOME CARE, LLC
Medical Inquiry

Name: _____

Address: _____

Telephone: (_____) _____

After reading your job description, can you perform all requirements of that position:

With Restrictions ☐ or Without Restrictions ☐

If restrictions are needed, please list them below: _____

_____

_____

Do you have any physical impairments or physical defects? _____
If yes explain: _____

_____

_____

Have you ever had a back injury? _____
If yes explain: _____

_____

_____

When was the last time you visited your doctor and the results:
Date: _____
Doctor: _____
Address: _____
Results: _____

In case of an emergency or accident, whom shall we notify? _____

_____

_____

_____ _____
Employee Date

_____ _____
Agency Representative Date

ABUSE, NEGLECT AND/OR EXPLOITATION

Policy:

Mercy Home Care, LLC administrative staff informs all staff members of mandatory reporting for cases of abuse, neglect or exploitation of its clients.

Procedure:

1. Each staff member's orientation includes a review of the following:
   a. Policies and procedures for client abuse/neglect.
   b. Disciplinary action in cases of client abuse and/or neglect by staff members or family.
   c. The internal reporting system for client abuse and/or neglect.
   d. The related mandatory reporting requirements imposed by the state statute.
   e. The fact that anyone may report suspected cases of abuse and/or neglect directly to the appropriate outside agencies.
2. Documentation of orientation is reflected in the staff member's employment file.
3. Individuals are mandated to report suspected client abuse and/or neglect if they:
   a. Have any knowledge of, or reason to suspects, client abuse and/or neglect.
   b. Have any knowledge of, or reason to suspect, client self-abuse.
   c. Have any knowledge that a client has sustained an injury that is not reasonable explained by the client's history of injuries.
4. Any individual (even those not mandated) may make reports of suspected client abuse and/or neglect.
5. The staff member reporting suspect client abuse and/or neglect:
   a. Immediately informs the Director of Nursing Services.
   b. Submits a written statement that is signed by the employee
6. Mercy Home Care, LLC's Director of Nursing or other designated personnel notifies outside agencies.
7. The Director of Nursing:
   a. Immediately reviews the completed form.
   b. Informs the Agency Administrator.
8. The Agency Administrator:
   a. Immediately submits a verbal report to the appropriate authority in accordance with state statutes.
   b. Reviews all reports.
   c. Conduct further investigation as necessary.
   d. Documents all reviews and investigations.
   e. Sends a copy of the completed report to the appropriate state agencies.
   f. Places copies of completed reports in the administrative file.
9. All reports, reviews, and investigations of suspected client abuse and/or neglect are held in strictest confidence.
10. If the Director of Nursing Services is suspected of committing client abuse and/or neglect, the individual reporting shall:
    a. Immediately inform the Agency Administrator.
    b. Immediately complete a suspected abuse report.

c. Submit the report to the Agency Administrator.

11. If the Agency Administrator is suspected of committing client abuse and/or neglect, the individual reporting shall:
    a. Immediately inform the President.
    b. Immediately complete a suspected abuse report.
    c. Submit the report to the President.

12. All staff members shall cooperate fully with those assigned to investigate any suspected cases of abuse and/or neglect.

13. Administrative staff will not implement retaliatory action against any individuals who report suspected abuse and/or neglect.

14. Any individual who is mandated to report suspected cases of client abuse and/or neglect, and who intentionally fails to report such suspected abuse and/or neglect, is guilty of a misdemeanor and liable for damages caused by the failure.

15. Individuals who willfully make false accusations are liable for civil action for any damages suffered by the individuals who were reported as suspects.

16. Information gathered will be handled in the following manner:
    a. If it is determined the information is false, it will be destroyed in two years after such determination.
    b. If it is determined the information is unsubstantiated, the information will be destroyed in four years after such determination.
    c. If it determined the information is substantiated, the information will be destroyed in seven years after such determination.

EMERGENCY/DISASTER PLAN

Policy:

All employees shall be oriented to the emergency/disaster plan along with their responsibilities in carrying out the plan, upon being hired.

Definition:

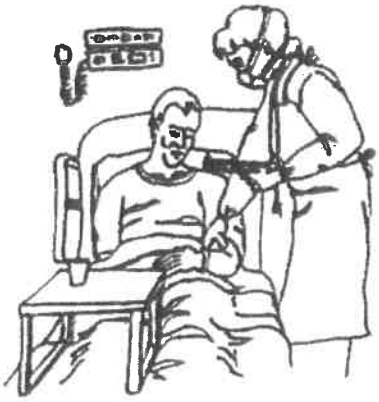
To assure that in the event of a natural disaster, inclement weather or chemical/nuclear accidents, the health care needs of clients will continue to be met. Employees must be oriented to their responsibilities in the emergency/disaster plan.

Procedure:

1. Upon admission to Mercy Home Care, LLC, all clients shall be instructed in the use of the emergency phone numbers, and the afterhours answering service.
2. In the event of an emergency/disaster, every effort shall be made to provide home health services to clients who are unattended. This coverage of health care services may be provided by family members or neighbors.
3. If there is no family or neighbor who can provide assistance and the client is physically/mentally incapable of caring for themselves, the client will be transported to the nearest hospital or health care facility. All efforts to provide health care coverage shall be documented and included in the client's clinical records.
4. In the event of an emergency/disaster and the employee is present in the client's home, the employee is to remain with the client until appropriate relief is obtained to meet the client's health care needs. The employee should attempt to contact the office to inform them of the client's status.
5. In the event of emergency or disaster, the Mercy Home Care, LLC office will not be opened. The answering service will take phone calls from clients and employees and promptly dispatch messages to the appropriate individuals. The client's health care needs will be assessed by the Director of Nursing via the telephone. All phone calls received and actions taken shall be properly documented. All attempts will be made to meet the client's health care needs.
6. Loud, high pitched alarms which are sounded for 3-5 minutes without interruption indicate an emergency/disaster situation. In areas where sirens may not be heard, the police or public address system may be used to indicate emergency/disaster. The employee is to turn on the radio or one of the Emergency Broadcast Systems (EBS) stations which will advise them of what actions to take. In the event of an emergency or disaster, the phones are to be used to summon help only.

Bloodborne Diseases Have Always Been a Concern

Bloodborne diseases have historically been a serious concern in the United States. Two diseases cause most of the problems.



"Hepatitis B" has been around the longest. It:

- Is the most prevalent form of Hepatitis.
- Infects over 70,000 people annually.
- Has over one million "carriers" in the U.S.

Over three million people carry the Hepatitis C (HCV) virus, the newest form of Hepatitis. But "Human Immunodeficiency Virus (HIV)" which is spreading rapidly in the United States, is the most publicized bloodborne disease. It is estimated that HIV (which usually leads to AIDS) currently infects over one million people.

In 1991 OSHA passed a "Bloodborne Pathogens" regulation, which calls for employers to do a number of things aimed at preventing their employees from becoming infected with these types of diseases.

These requirements include establishing "Safe Work Practices", setting up Engineering controls, and posting Warning Labels and Signs. A copy of your employer's Exposure Control Plan, detailing these practices is available for you to review.

Terms and Definitions are Important

In order to understand how bloodborne diseases are transmitted, and how to protect yourself from them, it is necessary to know some of the terms that are used when these diseases are discussed.

"Blood" is used to mean human blood, its components, or products made from human blood. "Bloodborne Pathogens" refers to micro-organisms present in blood which can cause a disease such as HIV, HBV, or HCV.

"Other Potentially Infectious Materials" includes:

- Human body substances.
- Contaminated body materials.
- Unfixed human tissue and organs.
- HIV and HBV cultures.
- Infected experimental animals.

"Contaminated" means having infectious materials on an item or surface.

A "Source Individual" is someone who may be infected, and could be a source of exposure.

"Standard Precautions" means approaching all human blood and other body fluids as if they contain Bloodborne Pathogens.

HIV Is One Major Bloodborne Disease

Human Immunodeficiency Virus (HIV) is the most "deadly" bloodborne disease in the United States. One of the reasons that it is spreading so rapidly is that there is no vaccine for HIV … and no known cure.

There is a great deal of research going on to develop both a vaccine and a treatment therapy for HIV, but to date no vaccine has been found.

Symptoms of HIV infection include:

- Weakness.
- Fever.
- Sore throat.
- Nausea.
- Headaches.
- Diarrhea.
- Other "flu-like" symptoms.

Many times, people who become infected with HIV exhibit these symptoms fairly quickly. But it is also possible for HIV victims to show no apparent symptoms for years after their infection.

Most people with HIV eventually develop AIDS. Once this happens, their immune system begins to break down. As a result, diseases such as Pneumonia and Tuberculosis (that they could normally fight off easily with antibiotics and other modern medicines) become fatal.

Hepatitis Is the Other Major Bloodborne Disease

The symptoms for Hepatitis B and C are similar to those for HIV, in that many of them are "Flu-like" in nature.

Hepatitis symptoms include:

- Fatigue.
- Stomach pain.
- Loss of Appetite.
- Nausea.
- Jaundice.

Jaundice is probably the most recognizable symptom, turning the skin, eyes, urine and even fingernails a dark yellow color.

Hepatitis attacks the liver, and one of its first effects is to inflame it significantly. Later, Hepatitis can often cause cirrhosis of the liver or even liver cancer.

While there is no vaccine for Hepatitis C, fortunately there is a vaccine that can prevent Hepatitis B infection. If there is a potential for you to be exposed to Hepatitis B, it is important for you to participate in your employer's vaccination program.

You should report any "exposure incident" immediately after it occurs. If you haven't had a recent Hepatitis vaccination, you may still be able to be treated after your exposure…but it is very important to begin as soon as possible.

There Are Several Ways to Reduce Exposure

There are three major ways to reduce exposure to Bloodborne Pathogens: Engineering Controls, Work Practice Controls, and using PPE.

"Engineering Controls" refer to equipment such as ventilating laboratory hoods, sharps with engineered injury protections such as self-sheathing needles, and puncture-resistant sharps containers…that can prevent you from encountering Bloodborne Pathogens.

"Work Practice Controls" are safer ways to perform tasks. Hand washing is an especially important example. You should wash your hands immediately after removing gloves or other PPE that may have become contaminated. You should also wash your hands after direct contact with blood or other potentially infectious materials.

OSHA also feels that good "housekeeping" practices are important, and requires facilities to:

- Perform periodic cleaning.
- Draw up Written Cleaning Schedules.
- Decontaminate all surfaces after contact with any infectious materials.
- Change equipment coverings if they are contaminated.

Needles and Other "Sharps" Have Special Controls

Needles and other "sharps" have their own controls. They:

- Cannot be bent.
- Should not be recapped.
- If recapping mush be done, a mechanical or one-handed technique must be used.

Contaminated "sharps" must be discarded into containers that are closable, puncture-resistant and leak-proof.

Contaminated laundry should be handled as little as possible, and always while wearing Personal Protective Equipment. Laundry should be bagged or containerized, and transported in labeled or color-coded bags.

Equipment must be decontaminated if possible. Otherwise, Biohazard Labels should be applied, and employees should be warned about possible contamination.

The Standard also governs the handling of other "regulated waste". If your job involves waste handling, make sure you know what the requirements are.

You should also develop good personal work habits where exposure to Bloodborne Pathogens may occur. Do not eat, drink, or smoke or apply cosmetics in these areas.

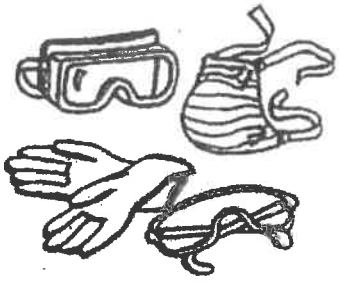
Personal Protective Equipment Is Especially Important

OSHA regards the use of Personal Protective Equipment as extremely important. They require that it be worn whenever there is a chance of exposure.

Gloves must be used whenever hand contact is anticipated. Disposable gloves must be replaced as soon as they are contaminated. Other gloves can be reused, once they are decontaminated.

Mouth and eye protection are especially important if you might be splashed or splattered with infectious material. Goggles provide the best eye protection. "Pocket" or face masks should be worn to protect the mouth.

Gowns, aprons and lab coats are commonly used to protect the bulk of the body. They should be selected based on type of exposure you are facing.



If you are involved in work where heavy contamination is anticipated, you should also wear:

- A surgical cap.
- A hood.
- Shoe covers or boots.

A "full body suit" may even be called for.

If you face exposure situations, PPE will be available in your work area. Take of any PPE before leaving the area, and deposit it into "collection" containers.

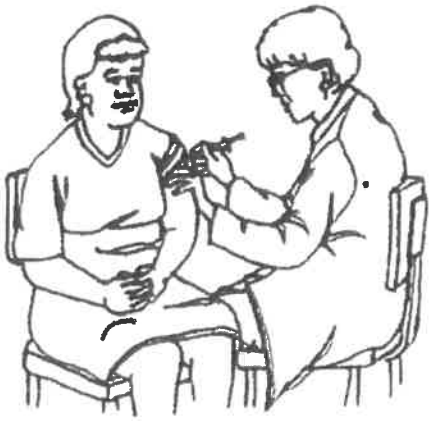
Vaccination Is Available for Hepatitis B

Vaccination is always the best way to guard against infection from any disease. While there is no vaccine for HIV or Hepatitis C, there is a Hepatitis B vaccine, which has been thoroughly tested. It is administered in a series of three injections.

Your facility's HBV Vaccination Program:

- Is available at no charge.
- Is for anyone who may be exposed to Bloodborne Pathogens.

If you refuse to participate in the program you must sign an OSHA "Declination Form".



As you can see, OSHA feels it is very important that you are vaccinated against Hepatitis B if you face potential exposure to Bloodborne Pathogens. If you have questions about the program, or would like more specific information, see your supervisor.

If you are exposed to Hepatitis B, and have not been vaccinated, an accelerated "post-exposure vaccination" is available. This is also free of charge. While post-exposure vaccination will not always prevent infection, it can frequently be helpful in combating Hepatitis B.

Accidents Involving Infectious Materials Can Happen

If you are exposed to an infectious material, wash the area with soap and water immediately.

If the material has "spilled" onto other surfaces:

- Contain it using absorbent barriers.
- Remove any remaining material with absorbent.
- Disinfect the spill area.
- Dispose of materials that are contaminated.
- Discard or recycle contaminated PPE.

Once you have dealt with the immediate problem, you will need to notify a number of people about the incident. First advise your immediate supervisor.

Next, your Environmental Services Department (if you have one), as well as your Safety Supervisor should be informed. Finally, if you are in a facility that has an Infection Control Department, you will need to notify them as well.

After all the appropriate people have been notified, you will need to complete an "Incident Report". This provides your facility with information about the incident, and will help them determine what, if anything needs to be done medically.

Steps Will Be Taken If You Are Exposed

If you are involved in an exposure incident, a number of steps will be taken. First, your employer will provide a written description of the incident. It will include the routes of exposure and the identity of the "source individual", if it is known. Your blood will also be tested for HBV, HCV, and HIV.

An appointment with a doctor will be arranged for you. They will be given information about the work you were doing when you were exposed, the incident itself, and the results of the "source individuals" blood tests. They will also be given copies of your relevant medical records.

Based on this information, they will discuss the results of your blood tests with you, as well as recommend any appropriate treatment.

Once the doctor has completed their evaluation, they will notify your employer:

- That you have been informed of the results.
- That they have discussed any medical issues with you.
- Whether HBV vaccination is called for.
- If you have had the first part of the vaccination.

All other information from you medical evaluation will remain confidential.

Remember...

- Exposure to Bloodborne Pathogens can be greatly reduced by following proper workplace procedures.
- Biohazard Warning Labels should be used to identify most infectious materials.
- Engineering Controls, such as puncture-resistant sharps containers, should be used where appropriate.
- Personal Protective Equipment, especially gloves, should be used whenever there is the potential for exposure.
- Never eat, drink, smoke or apply cosmetics in an area where exposure may occur.
- It is essential to participate in your company's Hepatitis B Vaccination Program.

QUIZ
BLOODBORNE PATHOGENS

Name: _____ Date: _____

1. Which of the following are the two most prevalent Bloodborne diseases in the United States?
   _____Hepatitis B.
   _____HIV.
   _____Tuberculosis.
   _____Mononucleosis.

2. Approximately how many new cases of Hepatitis B occur in the United States each year?
   _____70,000.
   _____300,000.
   _____3 million.

3. True or False... Vaccines do exist that can prevent infection from Hepatitis C and HIV?
   _____True
   _____False

4. What is the most important personal hygiene practice for preventing infection from Bloodborne diseases?
   _____Cleaning Fingernails Daily.
   _____Hand Washing.
   _____Gargling With Disinfectant.

5. What color must be used as the "background" on Biohazard Warning Labels?
   _____Yellow.
   _____Red/Orange.
   _____Black.

6. True or False... All types of gloves can be reused after an exposure incident if they are decontaminated?
   _____True
   _____False

7. True or False... Personal Protective Equipment can help guard against infection by Bloodborne pathogens?
   _____True
   _____False

MERCY HOME CARE, LLC
Authorization Agreement for Direct Deposits
(ACH Credits)

I hereby authorize Mercy Home Care, LLC, hereinafter called COMPANY, to initiate credit entries to my checking/savings account indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to credit the same to such account. I acknowledge that the organization of ACH transactions to my account must comply with the provisions of U.S. law.

NOTE:
To activate direct deposit, a voided check or deposit slip must accompany this form.

Depository
Name: _____ **Checking or Savings**
(Please Circle One)

City: _____ State: _____

Routing No.: _____ Account No.: _____

This authorization is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and in such manner as to afford the COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Name: _____
(Please Print)

Date: _____ Signed: _____

*****PLEASE MAKE SURE ACCOUNT NUMBER IS ON PAPER*****

I, _____ (*Print Employee Name*), have received and understand the Mercy Home Care, LLC: Employee Handbook. I understand this employee handbook contains policies and procedures to be followed by all employees, through-out employment with Mercy Home Care, LLC.

Employee Signature

Mercy Home Care, LLC. Office Staff Member

After Mercy Home Care, LLC: Employee Handbook is reviewed, this page is to be signed and returned to

OFFICE

Mercy Home Care, LLC
105 S. Andover Rd.
Suite C
Andover, Ks 67002

MAILBOX

Mercy Home Care, LLC
P.O. Box 580
Andover, Ks 67002

Kansas Department of Revenue

Motor Vehicle Records (Drivers License and Vehicle Title/Registration records)

3rd Party Consent (Please print or type)

I hereby certify that my name is _____
(First name) (Middle Initial) (Last Name)

I further certify that my date of birth is ____/____/____, my driver's license number is _____, my tag number is NA, my vehicle identification number is NA, my current address is:

_____
(Street) (Apartment/Unit) (City) (State) (Zip)

and my telephone number is _____.

I hereby authorize MERCY HOME CARE, LLC 822 N ANDOVER RD ANDOVER KS 67002
(First name) (Middle Initial) (Last Name)
to obtain my vehicle registration and/or driver's license record information including my personal information on those records.

_____ _____
(Signature) (Date)