TRUST HOME CARE LLC
PROVIDING QUALITY CARE TO THE COMMUNITY SINCE 2010

APPLICATION FOR EMPLOYMENT

222 S 9th Street
Unit:1600
Minneapolis, MN 55402
(P) 763-501-0792 (F) 612-465-2172

Instructions:

Step 1: Save this application and the Confidential Affirmative Action Form to your computer.
Step 2: Complete this Application for Employment and the Confidential Affirmative Action Form and save.
Step 3: Email both forms and your resume (if applicable) as attachments using the Position Title as the subject line to: trusthomecarellc@gmail.com.

Position Title: Personal Care Attendant **Today's Date:**

First Name: _____ MI: _____ **Last Name**: _____

Address: _____ City: _____ ST: _____ Zip: _____

Primary Phone with Area Code: Other Phone with Area Code:

Email Address: Other Contact Info:

A. How did you learn about this employment opportunity? (Check any that apply)
Newspaper: ☐ Job website: ☐ LSS website: ☐ If Employee Referral, provide employee name:
Other (please specify):

B. Are you able to provide proof that you are at least 18 years of age? Yes ☐ No ☐

C. Are you legally authorized to work in the United States? Yes ☐ No ☐

D. Do you have a valid driver's license? *(May be required for some positions)* Yes ☐ No ☐
Driver License# _____

Or State ID# _____ D.O. B _ _/ _ _/ _ _ _ _

E. Do you have a current Certified Nursing Assistant (CNA) certification? *(**Not required** for position at Trust Home Care LLC)* Yes ☐ No ☐

F. EMPLOYMENT HISTORY

Please begin with your current or most recent employment, or volunteer activity.

Name of employer:
Employer address:
Dates of your employment: From To
Your position title:
Briefly describe your responsibilities in this position:
Name/Title of supervisor:
May we contact this person for a reference? Yes ☐ No ☐ Phone with Area Code: ( ) *(Ext)*
Why did you leave this position?
Salary:

Name of employer:
Employer address:
Dates of your employment: From To
Your position title:
Briefly describe your responsibilities in this position:
Name/Title of supervisor:
May we contact this person for a reference? Yes ☐ No ☐ Phone with Area Code: ( ) *(Ext)*
Why did you leave this position?

Name of employer:
Employer address:
Dates of your employment: From To
Your position title:
Briefly describe your responsibilities in this position:
Name/Title of supervisor:
May we contact this person for a reference? Yes ☐ No ☐ Phone with Area Code: ( ) *(Ext)*
Why did you leave this position?

G. EDUCATION

High School Name:		City:	State:
	Did you graduate? Yes ☐ No ☐	Degree/Certification:	
College Name:		City:	State:
	Did you graduate? Yes ☐ No ☐	Degree/Certification:	
Other Name:		City:	State:
	Did you graduate? Yes ☐ No ☐	Degree/Certification:	
Other Name:		City:	State:
	Did you graduate? Yes ☐ No ☐	Degree/Certification:	

H. **OTHER QUALIFICATIONS:** Include relevant details, such as type, expiration date, etc.

Certification/Licensure	
Bi-Lingual Skills (List Languages)	
Special skills/other qualifications	

Trust Home Care, LLC.
222 S 9th Street
Unit: 1600
Minneapolis MN, 55402
(763) 501 0792
Affirmative Action/Equal Opportunity Employer

Name:_____Last First_____Initial____

Address:_____City_____State_____Zip_____

Position: _____

Date: _____

IMPORTANT – PLEASE READ

To enable Trust Home Care LLC, to meet government reporting requirements, you are requested to complete the questions listed below. Your completion of these questions is strictly voluntary. The information you provide will be treated as personal and confidential and will be used solely for statistical
purposes. It will not be retained with your employment record or used in the employment selection process. If you choose not to provide this information, please check the mark below indicating your decision. This election will also have no effect on the employment process.
*** I decline to provide the information requested below.
Race/Ethnic Identity (check one)

_____ White Not Hispanic. All persons having origins in any of the original peoples of Europe, North Africa or Middle East.

_____ Black Not Hispanic. All persons having origins in any of the Black racial groups of Africa.
_____ Hispanic All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

_____ Asian or All persons having origins in any of the original peoples of the Far Pacific Islander East, Southeast, Asia, the Indian Subcontinent or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.

_____ American Indian All persons having origins in any of the original peoples of North or Alaskan Native America and who maintain cultural identification through tribal affiliation or community recognition.

Sex:_____Female ***** Male

Physical or Mental Impairment (check all the following that apply)

____ Hearing impairment_____Visual impairment_____Mobility impairment

____ Learning disability_____Other (explain) _____

I. AVAILABILITY

Please check the times you are available to work:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM	☐	☐	☐	☐	☐	☐	☐
PM	☐	☐	☐	☐	☐	☐	☐
Overnight	☐	☐	☐	☐	☐	☐	☐

Please check the specific positions for which you wish to be considered:
Hiring Rate $14.65/hr. unless otherwise noted.

Special Accommodations:

An individual with a disability or medical condition may request a reasonable accommodation at any time during the application process or during the period of employment. To request an accommodation to support your participation in the interview process, please provide the following information.

My specific functional limitation:

The accommodation I am requesting:

To complete this application, read, sign, and date the Agreement below

I have certified that the information provided on this application is true and complete. I agree that if there is any misrepresentation or omission concerning the information on this application, any offer of employment to me may be withdrawn, and if I have already been hired, my employment may be terminated. I authorize investigation of all statements contained in this application.

I understand that any offer of employment by this organization is contingent upon (1) my providing sufficient documentation necessary to establish my identity and eligibility to work in the United States, (2) successful completion of any pre-employment background investigations that may be required by this employer, (3) proof of a valid driver's license and a satisfactory driving record for those positions involving driving a motor vehicle, and (4) Meeting the physical requirements of the position, with or without accommodation.

No promises concerning the nature or length of my employment have been made to me. If I am hired, I understand that I have the right to terminate my employment at any time, and for any reason. I understand that the organization has the right to terminate my employment at any time and for any reason. I understand that if or when my employment is terminated, by the organization or by me, that the organization may respond fully to reference inquiries from prospective employers. I understand that no one employed by the organization has the authority to modify these conditions, except in a written document signed by the President of the organization.

☐ **By checking this box, I hereby acknowledge that I have read and understand the foregoing.**

Please email application to trusthomcarellc@gmail.com
Email should include **Position Title** on the **Subject Line**

Signature: Date:

(Actual signature may be requested at later date)

Minnesota Department of **Human Services**

DHS-4469-ENG 11-16

Minnesota Health Care Programs (MHCP)

Individual PCA EnrollmentApplication

Complete this form online, print and then fax to MHCP. Complete at least all bolded fields to enroll an individual PCA. We will return incomplete forms to you.

◯ New hire (requires new background study and completion of PCA training)

◯ Rehire (requires new background study and completion of PCA training) – PREVIOUS EMPLOYMENT END DATE: _____

◯ Previously used for managed care organization (MCO) claims only (new background study not required)

Individual PCA Information

PROVIDER TYPE **38 – INDIVIDUAL**	**LEGAL NAME (FIRST)**	**FULL MIDDLE NAME**	**LAST NAME**	**SOCIAL SECURITY NUMBER**
ADDRESS (RESIDENTIAL ADDRESS ONLY – DO NOT ENTER A PO BOX)		**CITY**	**STATE**	**ZIP CODE**
COUNTY OF RESIDENCE	PHONE NUMBER	**DATE OF BIRTH**	**UMPI** (if requesting reinstatement)	
INDIVIDUAL PCA TRAINING DATE PASSED:_____ CERTIFICATION NUMBER:_____			**Is the individual 18 years old or older?** ◯Yes ◯No* *May affiliate with only one agency	
If previously used for MCO only claims, has this individual maintained continuous employment with your agency? ◯Yes ◯No				**BGS NUMBER or APPLICATION ID**

Individual PCA Provider Statement

I have reviewed and certify the information provided above is true and correct to the best of my knowledge. **I will notify the Minnesota Department of Human Services Provider Enrollment of any additions or changes to the information.**

By signing this form, I acknowledge I have read and understand the Application and Background Study Privacy Notice. I also authorize the Minnesota Department of Human Services to use the information collected about me according with the Privacy Notice.

NAME OF PCA (print or type)	**SIGNATURE OF PCA**	**DATE SIGNED**

Group Affiliation Information

You have the option to affiliate or enroll the individual PCA named above, if 18 years old or older, with other agencies you directly own without completing another application and agreement. Do you want to affiliate the above named individual PCA with any other agenciesyou own? ◯Yes ◯No (If yes, enter information below.)

ORGANIZATION OR AGENCY NAME	AGENCY NPI OR UMPI	STUDY ID

Agency Information

AGENCY NAME	AGENCY NPI OR UMPI	AGENCY FAX NUMBER
Trust Home Care LLC	**A983428700**	**612-465-2172**

AGENCY PERSONNEL COMPLETING FORM	AGENCY SIGNATURE

Next Steps

Read, sign and date the MHCP Provider Agreement - Support Worker (PCA, CDCS and CSG) (DHS-4611), and return it with this application.

Fax the application and agreement to 651-431-7465. Only faxed requests will be processed.

Clear Form

Minnesota Department of **Human Services**

DHS-4611-ENG

DHS-4611-ENG 4-15

Minnesota Health Care Programs

Provider Agreement – Individual Support Worker (CDCS, CSG, PCA)

As a participating provider in health service programs administered by the Minnesota Department of Human Services (the Department), the Provider agrees to:

A. Submit documentation to your affiliated agency that fully discloses the extent of services provided to individuals under these programs. The documentation must be legible and meet the requirements of Minnesota Statutes Section 256B.0659, subdivision 12 for all individual support workers in CDCS, CSG, and PCA.

B. Furnish the Department, the Secretary of the U.S. Department of Health and Human Services (DHHS), or the Minnesota Medicaid Fraud Control Unit with such information as it may request regarding payments claimed for services provided under these programs.

C. Comply with all federal and state statutes and rules relating to the delivery of services to individuals and to the submission of claims for such services.

D. Accept as payment in full, amounts paid in accordance with schedules established by the Department, except where payment by the recipient has been authorized by the Department.

E. Make full disclosure of any convictions(s) of program crimes as required by 42 C.F.R. § 455.106.

F. Comply with all federal statutes, implementing regulations and guidance prohibiting discrimination on the basis of race, color, national origin, sex, age, religion and disability in any program or activity receiving federal financial assistance from DHHS; and to comply with the Minnesota Human Rights Act.

G. Render to recipients services of the same scope and quality as would be provided to the general public, within Minnesota Health Care Programs (MHCP) guidelines.

H. Comply with the provisions of any fully executed agreement and/or addendum required by the Department, which is incorporated herein by reference.

I. Comply with the advance directive requirements as required by 42 C.F.R. §§ 489.100 and 417.436.

J. Properly handle and safeguard protected information collected, created, used, maintained, or disclosed on behalf of the Department. For purposes of this Agreement, "protected information" means data subject to any of the following laws:

1. The Minnesota Government Data Practices Act (MGDPA), Minnesota Statutes Chapter 13, in particular § 13.46 ("welfare data");
2. The Minnesota Health Records Act § 144.291 and § 144.298;
3. The Health Insurance Portability and Accountability Act ("HIPAA"), including but not limited to the requirements of the Privacy Rule and the Security Regulations, 45 C.F.R. Part 160 and Part 164, subparts A and E.
4. Federal law and regulations that govern the use and disclosure of substance abuse treatment records, 42 U.S.C.S. § 290dd-2 and 42 C.F.R. § 2.1 to § 2.67; and
5. Any other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information.

DIRECT SUPPORT WORKER INITIALS	

NAME OF SUPPORT WORKER	UMPI

K. Comply with the laws described in section J. This includes the Provider:

1. Not using or further disclosing protected information created, collected, received, stored, used, maintained or disseminated in the course or performance of this Agreement other than as necessary to perform its obligations under this Agreement, or as required by law, either during the period of this Agreement or hereafter. See, respectively, 45 C.F.R. §§ 164.502(b) and 164.514(d), and Minn. Stats. § 13.05 subd. 3.
2. Using appropriate administrative, physical, and technical safeguards to prevent use or disclosure of the protected information other than as provided for by this Agreement and to ensure the confidentiality, integrity, and availability of any electronic protected health information (PHI) that it creates, receives, maintains, or transmits on behalf of the Department. Provider will not transmit PHI over the Internet or any other unsecure or open communications channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent than those described in 45 C.F.R. § 164.312. If the Provider stores or maintains PHI in encrypted form, the provider shall, at the Department's request, promptly provide the Department with the key or keys to decrypt such information. The Provider shall not forward previously encrypted data to any other party, unless otherwise required by this Agreement.
3. Mitigating, to the extent practicable, any harmful effects known to the Provider of a use, disclosure, or breach of security with respect to protected information by the Provider in violation of this Agreement.

L. Agree that this Agreement may be immediately terminated at the discretion of the Department if it determines that the Provider has violated a material term of the Agreement, including but not limited to, non-compliance by the Provider with the HIPAA Privacy Rule and Security Standards. If termination is not feasible, the Department shall report the breach to the Secretary of DHHS.

Upon termination of this Agreement, all of the protected information provided by the Department to Provider, or created or received by the Provider on behalf of the Department, that the Provider still maintains in any form, including information that is in the hands of subcontractors or agents of the Provider, shall be destroyed or returned to the Department, and the Provider shall retain no copies of such information. If it is infeasible to return or destroy the information, the Provider shall provide the Department notification of the conditions that make return or destruction infeasible, and shall extend the protections of this Agreement to such information and limit further use and disclosure of such information to those purposes that make return or destruction infeasible, for as long as the Provider maintains the information.

M. Agree that any ambiguity in this Agreement shall be resolved to permit the Department to comply with HIPAA, MDGPA, and other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information and other state and federal laws and regulations.

Upon signature, this Provider Agreement supersedes and replaces all former Provider Agreements the Provider has with the Department.

An individual applicant must personally sign the Provider Agreement. Please sign and date below, initial page 1, and return both page 1 and page 2 of this agreement. **Please retain a copy of the provider agreement for your files, and return the original to the Department of Human Services.**

NAME OF SUPPORT WORKER **(TYPE OR PRINT)**	TITLE

SIGNATURE OF SUPPORT WORKER	DATE

Please return page 1 and page 2 of this document

Agreement Summary

As an individual support worker, you are providing health care services to individuals. We require your enrollment in the Minnesota Health Care Programs (MHCP) so that you are represented on the claim as the person who provided the services. Knowing that a qualified individual provided the service ensures the safety of the people that the Minnesota Department of Human Services serves. It also allows the Department to perform auditing and tracking of services which protects against double-billing and other types of fraud. Before enrollment is approved, MHCP must make certain that:

1. There is no legal or other reason why you shouldn't provide these services,
2. You understand what is necessary to properly provide these services, and
3. You understand the need to protect the privacy of the people you care for.

To help ensure that each of these conditions is met, MHCP requires that you agree to the terms in the attached Provider Agreement. In general, this agreement requires that you:

A. Provide documents to your employer about the services you provide.

B. Provide documents to MHCP or other state and federal agencies related to the services you provide, when requested.

C. Comply with federal and state laws about the services you provide.

D. Accept payment made to your employer as payment in full for the services you provide. You cannot ask for nor accept additional payment from the client.

E. Disclose any criminal convictions you have related to Medicare, Medicaid, or title XX services.

F. Not discriminate against individuals because of their race, color, national origin, sex, age, religion or disability when you provide these services.

G. Provide the same quality of service to persons receiving public assistance as those who don't receive such assistance.

H. If you are enrolled to provide and bill for other services, you must continue to follow the requirements of the agreement you signed when you enrolled for those services. The terms of that agreement are different than the terms in the attached agreement.

I. Comply with federal requirements about advance directives. An advance directive is written instruction, such as a living will, to give a patient control over medical treatment decisions.

J. Properly protect private information about the people to whom you provide services, especially their health information.

K. Don't disclose the private information of someone for whom you provide services, unless it is needed for your work. This includes not discussing someone's private information unless your job requires it. Also, ensure that the information could not be accessed by someone who does not have permission to see it. This includes not leaving paperwork out where others can see it, and not sending private information over the internet.

L. Understand that this agreement may be canceled if you violate its terms. If this agreement is canceled, you must properly dispose of any private information you have about the people you serve so that it is not discovered by someone who does not have permission to see it.

M. Understand that by signing this agreement, you are agreeing to protect any private information you come in contact with in your job. When you protect private information, you are complying with federal and state laws, and you help the Department comply with these laws, as well.

This is a basic description of the terms of this agreement. By signing this agreement, you are agreeing to be legally bound by all of its terms. If you have questions about it, you should get answers to them before signing this agreement. If you need or want legal advice, you should contact your own attorney. For more information, please call 651-431-2700.

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

2023

Step 1: Enter Personal Information

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

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

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, other details, 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) Reserved for future use.

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

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

TIP: If you have self-employment income, see page 2.

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. 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).

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 income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

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.

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

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

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 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

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	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

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	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

Employment Eligibility Verification

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

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

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

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

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

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.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

STOP *Employer Completes Next Page* STOP

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

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

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

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

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

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

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	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For 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.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		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:		
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		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

MN Department of Human Services -Office of Inspector General Licensing Division
Legal Authority: Minn. Stat. § 245D.10, subd. 2 and 4

TRUST HOME CARE LLC
PROVIDING QUALITY CARE TO THE COMMUNITY SINCE 2010

Grievance Policy

I. POLICY

It is the policy of this DHS licensed provider **Trust Home Care LLC** to ensure that people served by this program have the right to respectful and responsive services. We are committed to providing a simple complaint process for the people served in our program and their authorized or legal representatives to bring grievances forward and have them resolved in a timely manner.

II. PROCEDURES

A. SERVICE INITIATION

A person receiving services and their case manager will be notified of this policy, and provided a copy, within five working days of service initiation.

B. HOW TO FILE A GRIEVANCE

1. The person receiving services or person's authorized or legal representative:
   a. should talk to a staff person that they feel comfortable with about their complaint or problem;
   b. clearly inform the staff person that they are filing a formal grievance and not just an informal complaint or problem; and
   c. may request staff assistance in filing a grievance.
2. If the person or person's authorized or legal representative does not believe that their grievance has been resolved they may bring the complaint to the highest level of authority in this program.
   - That person is **Denita Walker,** Owner/Manager

They may be reached at **222 S 9th Street, Unit 1600**
Minneapolis, MN 55402

763-501-0792

C. RESPONSE BY THE PROGRAM

1. Upon request, staff will provide assistance with the complaint process to the service recipient and their authorized representative. This assistance will include:
   a. The name, address, and telephone number of outside agencies to assist the person; and
   b. Responding to the complaint in such a manner that the service recipient or authorized representative's concerns are resolved.

2. This program will respond promptly to grievances that affect the health and safety of service recipients.
3. All other complaints will be responded to within 14 calendar days of the receipt of the complaint.
4. All complaints will be resolved within 30 calendar days of the receipt.
5. If the complaint is not resolved within 30 calendar days, this program will document the reason for the delay and a plan for resolution.
6. Once a complaint is received, the program is required to complete a complaint review. The complaint review will include an evaluation of whether:
    a. Related policy and procedures were followed;
    b. Related policy and procedures were adequate;
    c. There is a need for additional staff training;
    d. The complaint is similar to past complaints with the persons, staff, or services involved; and
    e. There is a need for corrective action by the license holder to protect the health and safety of persons receiving services.
7. Based on this review, the license holder must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the license holder, if any.
8. The program will provide a written summary of the complaint and a notice of the complaint resolution to the person and case manager that:
    a. Identifies the nature of the complaint and the date it was received;
    b. Includes the results of the complaint review; and
    c. Identifies the complaint resolution, including any corrective action.

D. The complaint summary and resolution notice must be maintained in the person's record.

Policy reviewed and authorized by:

Print name & title Signature

Date of last policy review: _____ Date of last policy revision: _____

222 S 9TH STREET, SUITE 1600, MINNEAPOLIS, MN 55402| (P) 763-501-0792| (F) 612 465-2172

EMPLOYEE ORIENTATION

POLICY

Each employee of the Trust Home Care LLC who provides direct care, supervision of direct care, or management of services for the Agency, shall complete an orientation to home care services to clients.

SPECIAL INSTRUCTIONS

Orientation for all employees, including those not involved in care delivery, shall include the following six topics:

1. Handling of emergencies and use of emergency services.
2. Reporting the maltreatment of vulnerable minors or adults.
3. Home Care Bill of Rights.
4. Handling of clients' complaints and reporting of complaints to the Office of Health Facility Complaints.
5. Services of the Ombudsman for Older Minnesotans, and the Ombudsman for Mental Health and Developmental Disabilities.

Completion of the orientation training shall be documented in the employee's personnel file.

Additional orientation shall be provided for employees who provide direct care services which includes, but is not limited to, the following areas:

1. Overview of Agency operation and services

a. Goals, philosophy and objectives

b. Organizational structure

c. Various disciplines (personnel within each)

2. Agency personnel policies

a. Review policy manual

b. Review employee handbook

c. Complete necessary forms
   1. I-9
   2. W-4

d. Current TB testing (refer to Health Screening Policy)

e. Photocopy of:
   1. Professional license/certification
   2. CPR/First Aid certificate (if applicable)
   3. Proper ID for I-9 verification

f. EEO Compliance

3. Orientation to clinical and written procedures

a. Position description—employee must sign

b. General Administrative Policies

c. Skills demonstration checklist (per Agency guidelines)

d. Professional Orientation Materials
   1. Daily/Weekly routine
   2. Recording procedure
   3. Supervision requirements
   4. Change orders
   5. Care Plan
   6. Modification
   7. Discharge policy
   8. Role of PCA in conjunction with responsibilities of professional staff
   9. Chart format -- various forms used within chart -- forms used in other disciplines.

4. Infection Control/OSHA Blood Borne Pathogen Policies

222 S 9TH STREET AVE, UNIT 1600, MINNEAPOLIS, MN 55402| (P) 763-501-0792| (F) 612 465-2172

EMPLOYEE MISCONDUCT

DISCIPLINARY POLICY

Employment with the Trust Home Care LLC is at will and either the Agency or an employee may terminate the relationship at any time, with or without notice. Either party may end the relationship without prior notice, but neither party may breech contracts. The Agency cannot violate state or federal laws, and generally cannot rightfully terminate employees who refuse to do something that is contrary to public policy and sound morality, such as breaking the law.

The annual performance appraisal program assesses an employee's performance, and where needed, recommends necessary improvement. If improvement doesn't occur or there is a decline, other action is taken. Unacceptable behavior is dealt with through positive disciplinary action. The process includes verbal and/or written warnings that call attention to work performance needing improvement, misconduct or violation of an Agency policy. Nothing in this policy arrogates the employment at will doctrine or creates any contracted relationship, either implied or directed.

The critical points in this policy are due notice, a chance to improve, and a review process.

GUIDELINES

- **Verbal and/or written warnings. These guidelines apply to performance and attendance related issues, and other less serious issues that require disciplinary actions, but not immediate dismissal.**
- **Suspension. Employees may be suspended with or without pay until an investigation of employee misconduct is investigated. If cleared of any wrongdoing, the employee is reinstated into his/her position or comparable employment, with back pay, if applicable.**
- **Termination. Conduct leading to immediate discharge includes, but is not limited to:**

  1. Falsifying records including time records, mileage, and/or visit documentation

  2. Interfering with efficient safe operations and client safety

  3. Stealing agency property, co-worker property, or client property

  4. Borrowing money from or offering to sell products/ services to clients and/or their families.

  5. Carrying firearms or other dangerous weapons while on agency premises or while providing services for the agency.

  6. Abuse, damage, or destruction of agency or client property

  7. Fighting or provoking a fight while on duty or while representing the agency

  8. Abusive or threatening language to agency staff, supervisors, or clients

  9. Any physical or emotional abuse of clients

  10. Possessing and/or communicating liquor or illegal drugs while at work or on agency premises.

  11. Sexual harassment

  12. "No Call-No Show" for scheduled hours with a home care client

  13. Insubordination

  14. Working more than 310 hours per month (for one OR multiple agencies) Individual PCAs will be paid for a maximum of 16 hours per day (up to 310 hours/month).

  15. Turning in timecards for hours worked when the client is hospitalized or is on vacation or away from home, and the PCA has not traveled with them.

PCA:_____ Sign:_____ Date:_____

PERSONAL CARE ASSISTANT (PCA) JOB DESCRIPTION

Position Purpose

The Personal Care Assistant performs personal care services to clients unable to live independently in the community without assistance. The Personal Care Assistant is a position created to serve the clients in the Minnesota Medicaid Personal Care Assistant Program. Clients must be in a stable medical condition and be able to direct their own care or have a designated responsible party. The Personal Care Assistant works within the guidelines of a plan of care established by the client, physician, and supervising RN. The PCA reports directly to the Nursing Supervisor.

Qualifications

Be eighteen (18) years of age or have been approved to work by the employer and met state guidelines for persons between the ages of 16-18 years

- Have demonstrated ability to work with little direct supervision and make appropriate judgments.
- Have demonstrated dependability, tact and ability to follow orders.
- Possess good interpersonal communication skills.
- Possess and maintain good physical and mental health, including current TB testing (refer To Health Screening policy).
- Have US Citizenship or evidence of alien work permit.
- Pass background study in State of MN
- Must not have jeopardized health and welfare of vulnerable adults through physical abuse, sexual abuse or neglect as defined in Minnesota Statutes Section 626.557.
- Must not misuse or show dependency on mood altering chemicals including alcohol.

Must have completed one or more of the following:

A Nursing Assistant training program or its equivalent, for which competency as a Nursing Assistant is determined according to a test administered by State Board of Vocational Technical Education **OR**

- A Home Health Aide-PCA training program using a curriculum recommended by Minnesota Department of Health OR
- An accredited educational program for registered nurses or licensed practical nurses OR
- A training program that provides the assistant with skills required to perform personal care assistant services specified by the Agency **OR**
- Determination by the supervising RN that the assistant has the skills required, through

training and experience, to perform the personal care services specified under Covered Services in Medical Assistance Manual.

Specific Functions/Responsibilities

- Provide bowel and bladder care.
- Perform skin care, including prophylactic routine and palliative measures documented in plan of care.
- Assist with range of motion exercises.
- Provide respiratory assistance.
- Perform transfers.
- Assist with bathing, grooming, and hair washing necessary for personal hygiene.
- Perform turning and positioning.
- Assist with medications (normally self-administered).
- Apply and maintain prosthetics and orthotics.
- Clean equipment.
- Assist with dressing/undressing.
- Provide assistance with food, nutrition and diet activities.
- Accompany client to obtain medical diagnoses or treatment.
- Provide services necessary to maintain client's personal health and safety.
- Assist client to complete daily living skills such as personal/oral hygiene.
- Assist with incidental household services.
- Complete the appropriate records to document cares given and pertinent observations.
- Respond and attend to client requests promptly.
- Maintain proper hand washing techniques.
- Maintain a safe client environment.
- Maintain client confidentiality; treat clients and families with respect.
- Understand, accept and respond to the emotional needs of each client.
- Participate in training programs to meet compliance requirements.
- Accept and fulfill assignments with the Agency; exercise judgment in accepting assignments.
- Perform other related duties and responsibilities as deemed necessary.

Personal Care Assistant May Not:

- Provide services except as employee of an enrolled provider company.
- Provide services not outlined in the plan of personal care services.
- Provide services that are not supervised by a Registered Nurse or Qualified Professional.
- Provide personal care services to clients for whom they are legal guardians or responsible party...
- Perform sterile procedures.
- Provide services in an adult or child foster home without prior approval from the Department of Human Services.

Physical/Environmental Demands

See ADA Requirements

I have read and understand the above job description of the Personal Care Assistant.

Signed_____Date _____