CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

COMMUNITY CARE LICENSING DIVISION
HOME CARE SERVICES BUREAU

PERSONNEL RECORD

(Form to be Completed by employee at the time of hire)

FOR HOME CARE ORGANIZATION USE ONLY
NAME OF HOME CARE ORGANIZATION
HOME CARE ORGANIZATION ADDRESS
HOME CARE ORGANIZATION NUMBER
DATE OF EMPLOYMENT
DATE OF SEPARATION

PERSONAL

NAME (LAST FIRST MIDDLE)		AREA CODE/TELEPHONE ( )
ADDRESS		DATE OF BIRTH
SOCIAL SECURITY NUMBER: (VOLUNTARY FOR ID ONLY)	DATE OF LAST TB TEST	RESULTS OF LAST TB TEST

HAVE YOU EVER BEEN EMPLOYED UNDER A DIFFERENT NAME? ☐ YES ☐ NO IF YES, PLEASE LIST ALL NAMES USED.

DO YOU POSSESS A VALID CALIFORNIA DRIVER'S LICENSE? ☐ YES ☐ NO CDL NUMBER:_____

POSITION INFORMATION

TITLE OF POSITION	TIME BASE

EMPLOYMENT

(List most recent experience first. If additional space is needed, please attach a separate page.)

NAME AND ADDRESS OF EMPLOYER	AREA CODE/ TELEPHONE	JOB TITLE AND TYPE OF WORK	REASON FOR LEAVING	DATES FROM	DATES TO
	( )				
	( )				
	( )				
	( )				
	( )				

Notes:

I hereby certify under penalty of perjury that I am 18 years of age or older and that the above statements are true and correct. I give my permission for any necessary verification.	
EMPLOYEE SIGNATURE	DATE

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

CRIMINAL RECORD STATEMENT

State law requires that persons associated with licensed facilities or Home Care Aide Registry applicants be fingerprinted and disclose any conviction. A conviction is any plea of guilty or nolo contendere (no contest) or a verdict of guilty. The fingerprints will be used to obtain a copy of any criminal history you may have.

Have you ever been convicted of a crime in California ? . . . . . ☐ YES ☐ NO

You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.

Have you ever been convicted of a crime from another state, federal court, military or jurisdiction outside of U.S.? . . . . . ☐ YES ☐ NO

Criminal convictions from another State or Federal court are considered the same as criminal convictions in California.

If you answer YES, give details on the back of this page indicating the nature and circumstances of each crime and the date and the location in which each crime occurred.

You must disclose convictions, including reckless and drunk driving convictions even if:

1. It happened a long time ago;
2. It was only a misdemeanor;
3. You didn't have to go to court (your attorney went for you);
4. You had no jail time or the sentence was only a fine or probation;
5. You received a certificate of rehabilitation;
6. The conviction was later dismissed, set aside or the sentence was suspended.

NOTE: IF THE CRIMINAL BACKGROUND CHECK REVEALS ANY CONVICTION(S) THAT YOU DID NOT DISCLOSE ON THIS FORM, YOUR FAILURE TO DISCLOSE THE CONVICTION(S) WILL RESULT IN AN EXEMPTION DENIAL, LICENSE APPLICATION DENIAL, LICENSE REVOCATION, OR EXCLUSION FROM A LICENSED FACILITY/ORGANIZATION.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses and any accompanying attachments are true and correct.

FACILITY/ORGANIZATION NAME		FACILITY/ORGANIZATION NUMBER	
YOUR NAME *(PRINT CLEARLY)*	YOUR ADDRESS	CITY	ZIP
SOCIAL SECURITY NUMBER *(SEE PRIVACY STATEMENT ON REVERSE SIDE)*	DATE OF BIRTH	DMV LICENSE NUMBER	
SIGNATURE		DATE	

I. Instructions to Respondents:

If you have been convicted of a crime in California, another state or in federal court, provide the following information:

(You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.)

What was the offense? _____

_____

_____

_____

In which state and city did you commit the offense? _____

_____

_____

When did this occur? _____

_____

_____

Tell us what happened. (Use additional sheets of paper if needed) _____

_____

_____

_____

_____

_____

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge.

Signature _____ ***Date*** _____

II. Instructions to Licensees:

If the person discloses a criminal conviction, review the person's statement and discuss it with your Licensing Program Analyst (LPA). Maintain this form in your facility/organization personnel file and send a copy to your LPA.

PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility/organization, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17, 1596.871, and 1796.19). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

NOTE: IMPORTANT INFORMATION
The Department is required to tell people who ask, including the press, if someone in a licensed facility/organization has a criminal record exemption. The Department must also tell people who ask, the name of a licensed facility/organization that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT SUSPECTED ABUSE OF DEPENDENT ADULTS AND ELDERS

NOTE: RETAIN IN EMPLOYEE/ VOLUNTEER FILE

NAME

POSITION

FACILITY

California law REQUIRES certain persons to report known or suspected abuse of dependent adults or elders. As an employee or volunteer at a licensed facility, you are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include care custodians and any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not paid for that responsibility (Welfare and Institutions Code (WIC) Section 15630(a)). **Care custodian** means an administrator or an employee of most public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff (WIC Section 15610.17).

PERSONS WHO ARE THE SUBJECT OF THE REPORT

Elder means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **Dependent Adult** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age and those admitted as inpatients in 24-hour health facilities (WIC Section 15610.23).

REPORTING RESPONSIBILITIES AND TIME FRAMES

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect occurred, shall complete form SOC 341, "Report of Suspected Dependent Adult/Elder Abuse" for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult.

Reporting shall be completed as follows:

- If the abuse occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) and resulted in serious bodily injury (as defined in WIC Section 15610.67), report by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within two (2) hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, but did not result in serious bodily injury, report by telephone to the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local LTCOP, and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, did not result in serious bodily injury, and was perpetrated by a resident with a physician's diagnosis of dementia, report by telephone to the local law enforcement agency or the local LTCOP, immediately or as soon as practicably possible. Follow by sending the written report to the LTCOP or the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, and was abuse other than physical abuse, report by telephone to the LTCOP or the law enforcement agency immediately or as soon as practicably possible. Follow by sending the written report to the local law enforcement agency or the LTCOP within two working days.

- If the abuse occurred in a state mental hospital or a state developmental center, mandated reporters shall report by telephone or through a confidential internet reporting tool (established in WIC Section 15658) immediately or as soon as practicably possible and submit the report within two (2) working days of making the telephone report to the responsible agency as identified below:
    - If the abuse occurred in a State Mental Hospital, report to the local law enforcement agency or the California Department of State Hospitals.
    - If the abuse occurred in a State Developmental Center, report to the local law enforcement agency or to the California Department of Developmental Services.

- For all other abuse, mandated reporters shall report by telephone or through a confidential internet reporting tool to the adult protective services agency or the local law enforcement agency immediately or as soon as practicably possible. If reported by telephone, a written or an Internet report shall be sent to adult protective services or law enforcement within two working days.

PENALTY FOR FAILURE TO REPORT ABUSE

Failure to report abuse of an elder or dependent adult is a MISDEMEANOR CRIME, punishable by jail time, fine or both (WIC Section 15630(h)). The reporting duties are individual, and no supervisor or administrator shall impede or inhibit the reporting duties, and no person making the report shall be subject to any sanction for making the report (WIC Section 15630(f)).

CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCOPs, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order. Any violation of confidentiality is a misdemeanor punishable by jail time, fine, or both (WIC Section 15633(a)).

DEFINITIONS OF ABUSE

Physical abuse means any of the following: (a) Assault, as defined in Section 240 of the Penal Code; (b) Battery, as defined in Section 242 of the Penal Code; (c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code; (d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water; (e) Sexual assault, that means any of the following: (1) Sexual battery, as defined in Section 243.4 of the Penal Code; (2) Rape, as defined in Section 261 of the Penal Code; (3) Rape in concert, as described in Section 264.1 of the Penal Code; (4) Spousal rape, as defined in Section 262 of the Penal Code; (5) Incest, as defined in Section 285 of the Penal Code; (6) Sodomy, as defined in Section 286 of the Penal Code; (7) Oral copulation, as defined in Section 288a of the Penal Code; (8) Sexual penetration, as defined in Section 289 of the Penal Code; or (9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code; or (f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions: (1) For punishment; (2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given; or (3) For any purpose not authorized by the physician and surgeon (WIC Section 15610.63).

Serious bodily injury means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation (WIC Section 15610.67).

Neglect (a) means either of the following: (1) The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise; or (2) The negligent failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise. (b) Neglect includes, but is not limited to, all of the following: (1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter; (2) Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment; (3) Failure to protect from health and safety hazards; (4) Failure to prevent malnutrition or dehydration; or (5) Failure of an elder or dependent adult to satisfy the needs specified in paragraphs (1) to (4), inclusive, for himself or herself as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health (WIC Section 15610.57).

Financial abuse of an elder or dependent adult occurs when a person or entity does any of the following: (1) Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; (2) Assists in taking, secreting, appropriating, obtaining, or retaining real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; or (3) Takes, secretes, appropriates, obtains, or retains, or assists in taking, secreting, appropriating, obtaining, or retaining, real or personal property of an elder or dependent adult by undue influence, as defined in Section 15610.70 (WIC Section 15610.30(a)).

Abandonment means the desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody (WIC Section 15610.05).

Isolation means any of the following: (1) Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls; (2) Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons; (3) False imprisonment, as defined in Section 236 of the Penal Code; or (4) Physical restraint of an elder or dependent adult, for the purpose of preventing the elder or dependent adult from meeting with visitors (WIC Section 15610.43).

Abduction means the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, of any elder or dependent adult who does not have the capacity to consent to the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, as well as the removal from this state or the restraint from returning to this state, of any conservatee without the consent of the conservator or the court (WIC Section 15610.06).

AS AN EMPLOYEE OR VOLUNTEER OF THIS FACILITY, YOU MUST COMPLY WITH THE DEPENDENT ADULT AND ELDER ABUSE REQUIREMENTS, AS STATED ABOVE. IF YOU DO NOT COMPLY, YOU MAY BE SUBJECT TO CRIMINAL PENALTY. IF YOU ARE A LONG-TERM CARE OMBUDSMAN, YOU MUST COMPLY WITH FEDERAL AND STATE LAWS, WHICH PROHIBIT YOU FROM DISCLOSING THE IDENTITIES OF LONG-TERM RESIDENTS AND COMPLAINANTS TO ANYONE UNLESS CONSENT TO DISCLOSE IS PROVIDED BY THE RESIDENT OR COMPLAINANT OR DISCLOSURE IS REQUIRED BY COURT ORDER (Title 42 United States Code Section 3058g(d)(2); WIC Section 9725).

I, _____, have read and understand my responsibility to report known or suspected abuse of dependent adults or elders. I will comply with the reporting requirements.

SIGNATURE	DATE

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

COMMUNITY CARE LICENSING DIVISION
HOME CARE SERVICES BUREAU

REGISTERED HOME CARE AIDE TRAINING LOG

INSTRUCTIONS: *This form is intended to provide Home Care Organizations with method to maintain a training verification log for each Affiliated Home Care Aide. Although maintenance of a Training Log is required per section 90-067(c)(1) of the Written Directives, the use of this specific form is not required. Home Care Organizations have flexibility to document training requirements that best fit their business needs.*

HOME CARE ORGANIZATION REQUIREMENTS: The Home Care Organization licensee must maintain a verification log of training for each affiliated Home Care Aide which includes the information listed in 90-067(c)(1) of the Written Directives. Documentation must be kept in personnel file for Department review.

AFFILIATED HOME CARE AIDE, LAST NAME	FIRST NAME	PERSONNEL ID (optional)
POSITION TITLE	HIRE DATE	REGISTRATION DATE

DATE TRAINING COMPLETED (MM/DD/YY)	TRAINING TITLE	BRIEF DESCRIPTION OF TOPICS COVERED	TRAINING ORGANIZATION NAME	INSTRUCTOR FIRST NAME & LAST NAME (If in-person training)	LOCATION OF TRAINING (If online, specify website)	TRAINING HOUR REQUIREMENTS (Enter hours in applicable column)	
						ENTRY LEVEL	ANNUAL

HOME CARE ORGANIZATION INSPECTION CHECKLIST

This checklist is designed to assist you and your employees in preparing for an unannounced inspection. This checklist covers the areas reviewed by your analyst at the time of the visit. Please review this checklist to ensure the following items are updated and, if required, contained in the appropriate files. Personnel and administrative records must be maintained at the Home Care Organization and available for review by the analyst.

POSTING

Requirement - *The following items must be posted in a conspicuous location, visible both to clients and Affiliated Home Care Aides:*	**California Health and Safety Code Section**	**Form Number (If Any)**
Business hours	1796.42(a)	
Home Care Organization license	1796.42(a)	

PERSONNEL RECORDS

Requirement - *The following documents must be kept in each licensee, employee, volunteer and Affiliated Home Care Aide's file at the licensed Home Care Organization in which they are employed:*	**California Health and Safety Code Section**	**Form Number (If Any)**
☐ Personnel record	1796.37(a)(12)	HCS 501
☐ For all individuals who are required to fingerprint and who have contact with clients or access to confidential client information:		
☐ A signed statement regarding their criminal record history. If sending the original to the Department, a copy will be sufficient.	1796.23(a); 1796.33; 1796.43(a)(1)	LIC 508
☐ Documentation of a criminal record clearance, criminal record exemption or transfer	1796.37(a)(12)	
☐ All communication received from the Caregiver Background Check Bureau by the Home Care Organization licensee including criminal record exemption needed requests, approvals, denials, closures and rescissions.	1796.37(a)(12)	
☐ A signed statement acknowledging the requirement to report suspected or known dependent adult or elder abuse and suspected or known child abuse.	1796.42(e)	SOC 341A

Requirement – *In addition to the above documents, the following documents must be kept in each Affiliated Home Care Aide's file at the licensed Home Care Organization in which they are employed:*	**California Health and Safety Code Section**	**Form Number (If Any)**
☐ Training verification log and documentation of successful completion of training	1796.44	
☐ TB clearance	1796.45	
☐ All communication received pertaining to the Affiliated Home Care Aide's registration on the Home Care Aide Registry including, but not limited to, approvals, denials, revocations and forfeitures.	1796.37(a)(12)	

ADMINISTRATIVE RECORDS

Requirement - *The following administrative documents must be kept at each licensed Home Care Organization:*	**California Health and Safety Code Section**	**Form Number (If Any)**
☐ Certificate of insurance for a valid workers' compensation policy covering Affiliated Home Care Aides	1796.42(b)	
☐ Valid employee dishonesty bond, including third-party coverage, with a minimum limit of ten thousand dollars ($10,000)	1796.42(c)	HCS 402
☐ Certificate of insurance for a general and professional liability insurance policy in the amount of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate	1796.42(d)	
☐ Documentation from the Department of any waivers and exceptions (if applicable)	1796.37(a)(12)	HCS 971
☐ Proof of completion of the Department orientation	1796.37(a)(7)	
☐ Suspected abuse reports (if applicable)	1796.42(e)	SOC 341

ADDITIONAL INFORMATION: APPLICATION DOCUMENTS

Requirement - *The following application documents shall be maintained by the licensed Home Care Organization and be complete, current and available for review:*	**Form Number (If Any)**
☐ Application For a Home Care Organization License	HCS 200
☐ Licensee Applicant Information	HCS 215
☐ Designation of Home Care Organization Responsibility	HCS 308
☐ Partnership/Corporation/Limited Liability Company Organization Structure	HCS 309
☐ Board of Directors' Statement	HCS 9165
☐ Partnership Agreement/Articles of Incorporation/Articles of Organization	HCS 281
☐ Program Description - A general overview of the program and services provided	
☐ Job Description(s) - Each Position	
☐ Personnel Policies	
☐ Affiliated Home Care Aide Training Plan	

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

REQUEST FOR LIVE SCAN SERVICE - COMMUNITY CARE LICENSING

Applicant Submission

1. ORI: **A0448**

2. Working Title: *(Check ✔ one)*

☐ Adult Resident other than Client ☑ Employee ☐ License, Certification, Applicant ☐ Volunteer ☐ Home Care Aide Registry Applicant

3. Authorized Applicant Type - Enter from list on Page 2, "DOJ Abbreviated CCLD Facility/Organization Type."

4. Agency Address Set Contributing Agency:

CA Dept of Social Services — Agency authorized to receive criminal history information

03502 — Mail Code *(five-digit code assigned by DOJ)*

PO BOX 94244 — Street No.

Mail Station 9-15-62 — Street or PO Box

N/A — Contact Name *(Mandatory for all school submissions)*

Sacramento, — City

CA — State

94244-2430 — Zip Code

( ) **N/A** — Contact Telephone No.

5. Applicant Information:

Name of Applicant: *(Please print)* _____ (LAST / FIRST / MI)

AKA's: _____ (LAST / FIRST)

CDL No. _____

DOB: _____ SEX: ☐ Male ☐ Female

Misc. No. BIL - _____ AGENCY BILLING NUMBER *(IF APPLICABLE)*

HT: _____ WT: _____

Misc. No.: _____ PERMANENT RESIDENT (i-551), OUT OF STATE DRIVER'S LICENSE OR I.D.

EYE Color: _____ HAIR Color: _____

Home Address: *(All applicants must complete)*

POB: _____

STREET OR PO BOX

SOC: _____

(See Privacy Statement on Page 4)

CITY, STATE AND ZIP CODE

6. Facility/Organization Number: 304700175 Level of Service ☑ DOJ ☑ FBI

If resubmission for fingerprint quality (select R2), list Original ATI No. _____

7. Employer: (*Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)*

ROZHOMECARE LLC — Employer Name

8891 — Street No.

WATSON ST STE103 — Street or PO Box

03502 — Mail Code *(five digit code assigned by DOJ)*

CYPRESS — City

CA — State

90630 — Zip Code

714-226-0366 — Agency Telephone No. *(Optional)*

8.

Live Scan Transaction Completed By: _____ (Name of Operator) Date _____

Transmitting Agency | LSID# | ATI No. | Amount Collected/Billed

Rozhome Care

In Home Respite Care Services

8891 Watson Street, Suite 103. Cypress CA 90630 | Phone: (714) 226 0366 | Fax: (714) 226 0766 |

E-mail: Briansrhc@gmail.com

INCIDENT REPORT NOTIFICATION

To Caregiver,

As a caregiver, you are required to report any incidences that may occur at the location Of a consumer. An Incident Report Form (on the next page) is attached to this application for Your use. This document shows your understanding of this requirement.

I _____ understand that an incident report form must Be filled out within 24 hours of any incidence occurrence and the agency office must be Notified.

_____

Caregiver's Name

_____ _____

Caregiver's Signature Date

Rozhome Care

In Home Respite Care Services

8891 Watson St. Suite 103. Cypress CA 90630 | Phone: (714) 226 0366 | Fax: (714) 226 0766 | E-mail: rozhomecare@gmail.com

INCIDENT REPORT FORM

(Patient/Employee related)

- Date of Incident: _____
- Description of Occurrence and cause of incident: _____

_____

_____

_____

_____

_____

_____

_____

_____

- Full name of person completing report: _____
- Name of person(s) involved: _____
- Significant persons notified: Yes___ No ___ Who_____

Rozhome Care
In Home Respite Care Services
8891 Watson Street, Suite 103. Cypress CA 90630 | Phone: (714) 226 0366 | Fax: (714) 226 0366 | E-mail: Briansrhc@gmail.com

APPLICANT CLASSIFICATION RECORD

EQUAL EMPLOYMENT OPPORTUNITY

Federal and State laws prohibit employment discrimination because of Race, Color, Religion, Age, Physical or Mental Disability, National origin, Veteran's status or Sexual orientation. Employers are required to collect certain information from job applicants, although you are NOT required to provide it.

This information is statistical purposes only and will not be used in the employment selection process.
This information will be retained separately from your employment application. To further ensure privacy of information, do not write your name of the form.
RozHome Care, believes in Equal Employment Opportunity. Please help us meet our record – keeping requirement by providing the following information:

Date:_____

Applicant's Sex: Male____Female_____

Applicant's Race:

- Asian/ Pacific Islander
- American Indian/Alaskan Native
- Black/African American
- Hispanic
- White/Caucasian

Are you a Vietnam-Era Veteran? Yes--- No---

Do you consider yourself disabled? Yes--- No---

Are you 40 years of age or Older? Yes--- No---

Rozhome Care

In Home Respite Care Services

8891 Watson Street, Suite 103. Cypress CA 90630 | Phone: (714) 226 0366 | Fax: (714) 226 0766 | E-mail: rozhomecare@gmail.com

RELEASE FORM

I agree to have any of the information and statements in this application, as well as my background investigated by RozHome *Care and* their employees and/or agents.
I understand that background investigated may include, but is not limited to, reviewing my education, employment history, any public records and personal references, either through a search of my social security number, name or other identifying information.

I hereby authorize *RozHome Care* or any qualified agent of *RozHome Care.* Bearing this document, or a copy thereof, to obtain information from public records, any present or former employer, school, police or persons having personal knowledge about me to furnish bearer with any and all information in their possession regarding me in connection with an application for employment

I hereby waive and release those entities, individuals and companies from any liability for damages of whatever kind or nature which may accrue to me, including the defamation and invasion of privacy, on account of reliance by such persons on information submitted on my employment application, and termination of my employment based on information obtained after commencement of my employment.

Applicant's Name:

_____

Address:

_____

Driver's License #: _____ Issuing State:_____

Other Names Known By:_____

Applicant's Signature: _____ Date:_____

Form W-4 (2017)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

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

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

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A**	_____
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	**B**	_____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C**	_____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D**	_____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E**	_____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F**	_____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	**G**	_____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	**H**	_____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

Form **W-4**
Department of the Treasury
Internal Revenue Service

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 IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074
2017

1 Your first name and middle initial	Last name	2 **Your social security number**

Home address (number and street or rural route)

3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.
Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

City or town, state, and ZIP code

4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶	7	

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

RozHome Care
8891 Watson street. Suite# 103
Cypress CA 90630
Phone: (714) 226-0366 – Fax: (714) 226-0766
RozHomeCare@gmail.com/ Moniquerhc@gmail.com

Employment Eligibility Verification

USCIS

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

Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States *(See instructions)*
- ☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- ☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*
- ☐ *For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:* **1.** Alien Registration Number/USCIS Number: _____ OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	**Date** (*mm/dd/yyyy*):

"Our mission is to provide supportive assistance to families with any type of disabilities"