APPLICATION FOR EMPLOYMENT

100 S 5th Street
Suite:1900
Minneapolis, MN 55402
(P) 763-501-0792 (F) 612-465-2172
(Office) 612-278-4061

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#_____ D.O. B _ _/ _ _/ _ _ _ _

Or State ID# _____

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.
100 S 5th Street
STE 1900
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 $12.65/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

2020

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

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

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

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

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

Step 3: Claim Dependents

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

▸ _____ **Date**

Employers Only

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

General Instructions

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

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

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

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

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

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

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

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

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

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

Step 4 (optional).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $18,650 if you're head of household
- $24,800 if you're married filing jointly or qualifying widow(er)
- $12,400 if you're single or married filing separately

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

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

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

EMPLOYEE ORIENTATION

POLICY

Each employee of the AGENCY NAME 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

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 275 hours per month (for one OR multiple agencies) Individual PCAs will be paid for a maximum of 16 hours per day (up to 275 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 _____