



RaySen Care Services

2805 Pontiac Lake Rd, Suite 1C, Waterford, MI 48328

Phone: (248) 701-2848 | Fax: (248) 439-0517

RaySenCareServices.com

APPLICATION FOR EMPLOYMENT

Position Applied For: _____

Date of Application: _____

How Did You Hear About Us?

☐ Advertisement ☐ Relative ☐ Inquiry ☐ Friend ☐ Website ☐ Other: _____

Name: _____

Address: _____

Phone Number: _____

Email Address: _____

Are you over 18 years of age? ☐ Yes ☐ No

Do you have reliable transportation? ☐ Yes ☐ No

Are you a licensed driver with active auto insurance? ☐ Yes ☐ No: _____

Have you applied for a position with us before? ☐ Yes ☐ No If yes, give date: _____

Have you been employed with us before? ☐ Yes ☐ No If yes, give date: _____

Are you currently employed? ☐ Yes ☐ No

May we contact your present employer? ☐ Yes ☐ No

Date available for work: _____

Desired salary range: _____

Are you available to work: ☐ Full-Time ☐ Part-Time ☐ Temporary

Other Qualifications:

Specialized Skills (check skills/equipment used): ☐ PC/MAC ☐ Word Processing ☐ Terminal ☐

Words/minute: _____

Employment Experience:

1. Employer Name: _____

Address: _____

Phone Number: _____

Dates: _____ to _____

Reason for leaving: _____

Hourly Rate: _____ Job Title: _____ Supervisor Name: _____

Duties included: _____

2. Employer Name: _____

Address: _____

Phone Number: _____

Dates: _____ to _____

Reason for leaving: _____

Hourly Rate: _____ Job Title: _____ Supervisor Name: _____

Duties included: _____

3. Employer Name: _____

Address: _____

Phone Number: _____

Dates: _____ to _____

Reason for leaving: _____

Hourly Rate: _____ Job Title: _____ Supervisor Name: _____

Duties included: _____

References (professional preferred):

1. Name: _____ Phone Number: _____

Address: _____

2. Name: _____ Phone Number: _____

Address: _____

3. Name: _____ Phone Number: _____

Address: _____

Applicant's Statement

I certify that the answers given herein are true and complete.

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

This application for employment shall be considered active for a period not to exceed 45 days.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with RaySen Care Services, Inc. is of an 'at will' nature.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. Part of the job requirement is that employees have to be MORC, TTI, First Aid, & CPR trained within the first 30 days of employment.

Signature of Applicant: _____ **Date:** _____

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

2024

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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, and when to use the estimator at www.irs.gov/W4App.

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). If you or your spouse have self-employment income, use this option; or (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; or (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate <input type="checkbox"/>
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Complete Steps 3–4(b) on Form W-4 for **only ONE** of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 \$ _____ Multiply the number of other dependents by \$500 \$ _____ Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	Employee's signature (This form is not valid unless you sign it.)		Date

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)
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Step 2(b)—Multiple Jobs Worksheet (Keep for your records.)

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

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; 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 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
- 2** Enter:

{	• \$29,200 if you're married filing jointly or a qualifying surviving spouse	}	2	\$ _____
	• \$21,900 if you're head of household				
	• \$14,600 if you're single or married filing separately				

- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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

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

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

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

MI-W4

(Rev. 12-20)

EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE STATE OF MICHIGAN - DEPARTMENT OF TREASURY

This certificate is for Michigan income tax withholding purposes only. Read instructions on page 2 before completing this form.

Issued under P.A. 281 of 1967.

▶ 3. Name (First, Middle Initial, Last)			▶ 1. Full Social Security Number		▶ 2. Date of Birth	
Home Address (No., Street, P.O. Box or Rural Route)			4. Driver's License Number or State ID			
City or Town			State		ZIP Code	
▶ 5. Are you a new employee?			(mm/dd/yyyy)			
<input type="checkbox"/> Yes If Yes, enter date of hire.....			<input type="checkbox"/> No			
6. Enter the number of personal and dependent exemptions (see instructions) ▶ 6.						
7. Additional amount you want deducted from each pay (if employer agrees) 7. \$.00						
8. I claim exemption from withholding because (see instructions):						
a. <input type="checkbox"/> A Michigan income tax liability is not expected this year.						
b. <input type="checkbox"/> Wages are exempt from withholding. Explain: _____						
c. <input type="checkbox"/> Permanent home (domicile) is located in the following Renaissance Zone: _____						
EMPLOYEE: If you fail or refuse to file this form, your employer must withhold Michigan income tax from your wages without allowance for any exemptions. Keep a copy of this form for your records. See additional instructions on page 2.						
<i>Under penalty of perjury, I certify that the number of withholding exemptions claimed on this certificate does not exceed the number I am allowed to claim. If claiming exemption from withholding, I certify that I do not anticipate a Michigan income tax liability this year.</i>						
9. Employee's Signature					▶ Date	

EMPLOYER: Complete the below section.			
10. Employer's Name		▶ 11. Federal Employer Identification Number	
Address (No., Street, P.O. Box or Rural Route)		City or Town	State
Name of Contact Person		ZIP Code	
		Contact Phone Number	
INSTRUCTIONS TO EMPLOYER: Keep a copy of this certificate with your records. All new hires must be reported to the State of Michigan. See www.mi-newhire.com for information.			
In addition, a copy of this form must be sent to the Michigan Department of Treasury if the employee claims 10 or more exemptions or claims they are exempt from withholding. Send a copy to: Michigan Department of Treasury Tax Technical Section P.O. Box 30477 Lansing, MI 48909			



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No.1615-0047

Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
		<input type="checkbox"/> 4. An alien authorized to work until (exp. date, if any)				
		If you check Item Number 4., enter one of these:				
		USCIS A-Number		OR	Form I-94 Admission Number	
				OR	Foreign Passport Number and Country of Issuance	
Signature of Employee				Today's Date (mm/dd/yyyy)		

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

List A		OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)		Additional Information			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.					
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.



**Supplement A,
Preparer and/or Translator Certification for Section 1**

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

**USCIS
Form I-9
Supplement A**
OMB No. 1615-0047
Expires 05/31/2027

Last Name (<i>Family Name</i>) from Section 1.	First Name (<i>Given Name</i>) from Section 1.	Middle initial (if any) from Section 1.
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Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

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

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

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

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

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

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

AUTHORIZATION AND RELEASE
CRIMINAL BACKGROUND CHECK

I understand that to provide respite services as an independent contract provider, a criminal background check must be completed. I have been informed that criminal history may disqualify me from providing respite services and understand that The Arc of Oakland, Inc. will notify me of the results. I further understand that The Arc of Oakland Inc. will notify the requested family of my eligibility to provide respite services.

I hereby authorize and release from all liability without reservation, RaySen Care Services, The Arc of Oakland, Macomb Oakland Regional Center, Inc., any law enforcement agency, administrator, state/federal agency, or institution gathering or furnishing the above information.

PLEASE INCLUDE A PHOTOCOPY OF A MICHIGAN DRIVER'S LICENSE OR STATE IDENTIFICATION

Signature: _____ Date: _____

Name (print): _____

Date of Birth (must be 18 yrs or older): _____

Male/Female (circle one)

Race (circle one): White, Black, Asian, Pacific Islander, American Indian or Alaskan Native, Unknown/Other

Print all other names previously used: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Respite Services for (name, print): _____

Address, City: _____

Send or fax to: The Arc of Oakland, Inc.
1641 W. Big Beaver Road
Troy, MI 48084
Fax: (248) 816-3340



**AUTHORIZATION TO DISCLOSE
EMPLOYEE INFORMATION
AND RELEASE OF LIABILITY**

Attachment B.1

I, _____, authorize Oakland Community Health Network (OCHN) to disclose to
(PRINT FULL LEGAL NAME)
the PROVIDER listed below any and all information in your possession regarding any violations of recipients' rights
committed by me. I recognize that any disclosures cannot include confidential client information protected by any Federal,
State or common law.

I, _____, release Oakland Community Health Network, its officers, its agents
(PRINT FULL LEGAL NAME)
and its employees from any and all liability, claims, suits and actions of any nature brought against Oakland Community
Health Network, its officers, its agents and its employees for disclosing the information requested by me and I shall
indemnify and hold them harmless should any such claims, suits or actions be filed against them.

APPLICANT SIGNATURE DATE

APPLICANT'S PREVIOUS NAME/S OR MAIDEN
NAME (IF APPLICABLE)

WITNESS SIGNATURE DATE

(Witness to ensure form is complete and
legible before sending to process.)

APPLICANT'S LAST 4 DIGITS OF SS#

INFORMATION TO BE SENT TO:

PROVIDER

APPLICANT'S DATE OF BIRTH
MONTH AND DAY ONLY

ADDRESS

DRIVER'S LICENSE #/STATE ID#

CITY STATE ZIP CODE

DATE OF APPLICATION/HIRE

PHONE

CONTACT PERSON

☐ Please fax this form back at _____ Attn: _____

☐ Please mail this form back to the Provider address above, or email to this
address _____

RIGHTS OFFICE USE ONLY

The above applicant does _____ does not _____ have substantiated recipient rights violation(s) according to Oakland
Community Health Network records.

By: _____ DATE: _____
Vicki L. Suder, Director of Rights and Advocacy

ORR/Authorization to Disclose Revision 10-23-18

S-FAX (855) 828-4983