



## *Personal Assistant* **Acknowledgment and Agreement Forms**

**This Personal Assistant enrollment packet contains acknowledgment and agreement forms that you need to read, sign, and return to Concepts. Your Consumer/Designated Representative will also go over them with you. These include:**

- PA Demographic Information Form (1 Pg.) [Page 2](#)
- PA Emergency Contact & Consumer Information Form (1 Pg.) [Page 3](#)
- PA Employment Agreement Form (3 Pgs.) [Pages 4-6](#)
- False Claims Act Form (1 Pg.) [Page 7](#)
- Deficit Reduction Act Form (1 Pg.) [Page 8](#)
- Relationship Disclosure Form (1 Pg.) [Page 9](#)
- Health Insurance Portability and Accountability Act (HIPAA) Form (1 Pg.) [Page 10](#)
- Hepatitis-B Vaccine Form (1 Pg.) [Page 11](#)
- Direct Deposit Authorization Form (1 Pg.) [Page 12](#)
- Debit Card – ADP Authorization Form (1 Pg.) \*Optional [Page 13](#)
- Debit Card – ADP Aline Enrollment Form (1 Pg.) \*Optional [Page 14](#)
- Life Insurance Beneficiary Designation – UNUM Form (2 Pgs.) [Pages 15-16](#)
- Federal Withholdings – W-4 Form (1 Pg.) [Page 17](#)
- NY State Withholdings – IT-2104 Form (1 Pg.) [Page 18](#)
- Employment Eligibility Verification – I9 Form (1 Pg.) [Page 19](#)
- Wage Notice – LS 62 Form (2 Pgs.) [Page 20-21](#)

**Below is a list of documents and additional information you will need to complete the forms above.**

1. Social security number
2. Names of emergency contacts and telephone numbers
3. Photo ID issued by a government agency
4. Valid email address
5. Voided check
6. Life insurance beneficiary information (name(s), address, date of birth, email, and telephone numbers)



***Personal Assistant  
Demographic Information***

**Personal Assistant Profile Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Alias/Preferred Name: \_\_\_\_\_ Pronouns: \_\_\_\_\_ Gender: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M  F

Home Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone 1: \_\_\_\_\_ Type: \_\_\_\_\_ Phone 1 Text Message Notification Approval\* (Y/N): \_\_\_\_\_

Phone 2: \_\_\_\_\_ Type: \_\_\_\_\_ Phone 2 Text Message Notification Approval\* (Y/N): \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Communication Method: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Secondary Language: \_\_\_\_\_ Date of Hire: \_\_\_\_\_

Translator Required (Y/N)? \_\_\_\_\_ Auditory Impairments (Y/N)? \_\_\_\_\_ Visual Impairments (Y/N)? \_\_\_\_\_

Ethnicity:  American Indian  Asian  Black or African American  
 Hispanic/Latino  Native Hawaiian or Pacific Islander  White

I attest that the information I have provided in this form is correct. I agree, and understand it is my responsibility, to notify Concepts of Independence, Inc. and my Consumer or Designated Representative of any changes to this information.

\_\_\_\_\_  
Personal Assistant Signature

\_\_\_\_\_  
Date

\* Standard messaging fees and data rates may be applied by your mobile service provider for any electronic communication. You may choose to opt out of receiving automated notifications via text message by responding "STOP" to any notification message or by visiting the site [https://form.jotform.com/CDPAP\\_CONCEPTS/CommunicationPreferences](https://form.jotform.com/CDPAP_CONCEPTS/CommunicationPreferences) and opting out of this service.



*Personal Assistant*

**Emergency Contact & Consumer Information**

Personal Assistant Name: \_\_\_\_\_  
Last Name
First Name
Middle Name

**PA Emergency Contact Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I.: \_\_\_\_\_  
 Phone 1: \_\_\_\_\_ Type: \_\_\_\_\_ Phone 1 Text Message Notification Approval\* (Y/N): \_\_\_\_\_  
 Phone 2: \_\_\_\_\_ Type: \_\_\_\_\_ Phone 2 Text Message Notification Approval\* (Y/N): \_\_\_\_\_  
 Email: \_\_\_\_\_ Preferred Communication Method: \_\_\_\_\_  
 Primary Language: \_\_\_\_\_ Relationship to Personal Assistant: \_\_\_\_\_

**Consumer & Designated Representative Information**

Name of Consumer: \_\_\_\_\_  
First Name
Last Name
Middle Name

Consumer's Phone #: \_\_\_\_\_ Consumer's Email: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Designated Representative (if applicable): \_\_\_\_\_  
First Name
Last Name

Designated Rep's Phone #: \_\_\_\_\_ Designated Rep's Email: \_\_\_\_\_

I attest that the information I have provided in this form is correct. I understand that my Consumer or Designated Representative may be contacted regarding my employment. Furthermore, I authorize communications, in the event of an emergency, with the person I have assigned as my emergency contact. I agree, and understand it is my responsibility, to notify Concepts of Independence, Inc. and my Consumer or Designated Representative of changes to my emergency contact information.

\_\_\_\_\_  
Personal Assistant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Consumer/Designated Representative Signature

\_\_\_\_\_  
Date

\* Standard messaging fees and data rates may be applied by your mobile service provider for any electronic communication. You may choose to opt out of receiving automated notifications via text message by responding "STOP" to any notification message or by visiting the site [https://form.jotform.com/CDPAP\\_CONCEPTS/CommunicationPreferences](https://form.jotform.com/CDPAP_CONCEPTS/CommunicationPreferences) and opting out of this service.





*Personal Assistant*  
***Employment Agreement (continued)***

**Consumer/Designated Representative (DR) – Additional Responsibilities**

- To schedule their Personal Assistant(s) in accordance with the LDSS/MMCO's authorization and Concepts' prevailing scheduling policy and maintain a back-up plan.
- To review the plan of care with their Personal Assistant(s) outlining their responsibilities.
- To inform their Personal Assistant(s) as to the rights and responsibilities of all involved parties.
- To instruct their Personal Assistant(s) as to the proper use of universal precautions. In addition, the Consumer/DR will inform their Personal Assistant(s) as to their choice to receive the Hepatitis B vaccine at no cost to the Consumer/DR or the Personal Assistant.
- To comply with all labor laws including, but not limited to, discrimination and harassment.
- To provide equal employment opportunities to all applicants.
- To hire only applicants who are legally authorized to work in the United States.
- To maintain a harassment-free workplace and provide each Personal Assistant with Sexual Harassment Prevention training and policy when they are hired and annually thereafter.
- To ensure their Personal Assistant is fully cleared to work prior to scheduling them for training or work, including the completion of a pre-employment health assessment, and that all PAs complete an annual health assessment every year no later than the expiration date of the previous health assessment.
- To ensure that no Personal Assistant clocks in to work while the Consumer is hospitalized.
- To submit all required documents in a timely manner, including Consumer and Personal Assistant enrollments, payroll documents, and any other Consumer or PA document.
- To ensure each Personal Assistant adheres to EVV (Electronic Visit Verification) requirements as defined by NYS Department of Health (DOH), and to train each PA as to the use/requirements of EVV.
- To ensure that their Personal Assistant(s) receive(s) the prevailing hourly rates of pay established by Concepts and provide their Personal Assistant(s) with all the benefits administered by Concepts.
- To distribute paychecks and/or paystubs to each Personal Assistant and permit each of them to participate in the Direct Deposit/Debit Card payroll distribution system.
- To try to resolve any payroll/personnel problems prior to contacting Concepts.
- To never request payment from any Personal Assistant in order for them to be hired or to keep their job.
- To report and return any overpayment or inappropriate payments from the Medicaid program made to your personal assistant(s).

**Definition of Personal Assistant per regulation NYCRR Title 18, section 505.28**

A Personal Assistant (PA) means an adult who provides consumer directed personal assistance to a Consumer under the Consumer's instruction, supervision, and direction or under the instruction, supervision, and direction of the Consumer's Designated Representative. A person legally responsible for the Consumer's care and support, a Consumer's spouse, or the Consumer's Designated Representative may not be the Personal Assistant for that Consumer; however, a Personal Assistant may include any other adult relative of the Consumer provided that the district or MMCO determines that the services provided by such relative are consistent with the Consumer's plan of care.



***Personal Assistant  
 Employment Agreement (continued)***

**Personal Assistant Agrees To:**

- Recognize the authority of the Consumer/Designated Representative (DR) as the Personal Assistant’s source of employment and supervisor and sole Common Law Employer.
- Respect the Consumer’s health, well-being, privacy, and property.
- Authorize Concepts to collect and appropriately distribute employment-related information.
- Receive a pre-employment health assessment and annual health assessments.
- Comply with the policies and practices of Concepts.
- Report to work on time and remain for the duration of the scheduled work period and perform tasks assigned during the entire work period in accordance with the Plan of Care.
- Accurately report the time worked on an EVV method and timely submit any EVV Exception Forms, as required.
- Coordinate vacation/leave time with the Consumer/DR with as much notice as possible.
- In case of illness or emergency, call the Consumer/DR as soon as possible prior to start of your shift.

**Fiscal Intermediary (Concepts of Independence) responsibilities per regulation NYCRR Title 18, section 505.28 – As it pertains to Personal Assistants (PAs)**

- (1) Fiscal intermediaries have the following responsibilities with respect to the CDPAS program:
- (i) processing each Personal Assistant's wages and benefits including establishing the amount of each assistant's wages; processing all income tax and other required wage withholdings; and complying with worker's compensation, disability and unemployment insurance requirements;
  - (ii) ensuring that the health status of each Personal Assistant is assessed prior to service delivery;
  - (iii) maintaining personnel records for each Personal Assistant, including EVV or timesheets and other documentation needed for wages and benefit processing and a copy of the medical documentation;
  - (iv) maintaining records for each Consumer including copies service authorization or reauthorization;
  - (iv) monitoring the Consumer's or the Designated Representative's continuing ability to fulfill their responsibilities and promptly notifying LDSS/MMCOs of any circumstance of non-compliance
- (2) Fiscal intermediaries are not responsible for fulfilling responsibilities of the Consumer or, if applicable, the Consumer's Designated Representative. Nothing in this section shall diminish, however, the fiscal intermediary's failure to exercise reasonable care in properly carrying out its responsibilities under the program.

**Employment Agreement**

I have read the information provided herein and agree to the terms outlined in the Employment Agreement.

**Personal Assistant:**

**Consumer:**

\_\_\_\_\_  
 First Name

\_\_\_\_\_  
 Last Name

\_\_\_\_\_  
 First Name

\_\_\_\_\_  
 Last Name

\_\_\_\_\_  
 Signature (Personal Assistant)

\_\_\_\_\_  
 Signature (Consumer or Designated Representative)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Date





***Personal Assistant  
 Deficit Reduction Act***

Personal Assistant Name: \_\_\_\_\_  
Last Name First Name Middle Name

Consumer Name: \_\_\_\_\_  
Last Name First Name Middle Name

The State of New York Medicaid reimbursement regulations prohibit payment for home care services while the service recipient (Consumer) is hospitalized or admitted to a health care facility. Therefore, if a Consumer is hospitalized or admitted to a health care facility, the Personal Assistant will not be paid for the Consumer’s inpatient stay. However, Personal Assistants may be paid from accumulated Personal Time Off (PTO).

Under the Federal Deficit Reduction Act of 2005, Concepts of Independence, Inc. is obligated to report every incident of suspected Medicaid fraud and abuse to the Department of Health and Human Services Office of Inspector General for false claims investigation and prosecution.

If Personal Assistant(s) are paid erroneously by Concepts of Independence, Inc. during a Consumer’s admission to the hospital/health care facility, the Personal Assistant is obligated to immediately return the full amount of overpayment to Concepts.

**Acknowledgment**

I understand that submitting false Electronic Visit Verification (EVV) or signing and submitting timesheets during the Consumer’s hospitalization, or admission to a health care facility, constitutes Medicaid fraud. I agree to notify Concepts of Independence, Inc. of the Consumer’s hospitalization immediately upon admission to the hospital/health care facility.

\_\_\_\_\_  
 Personal Assistant Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Consumer/Designated Representative Signature

\_\_\_\_\_  
 Date



***Personal Assistant  
 Relationship Disclosure***

Personal Assistant Name: \_\_\_\_\_  

Last Name
First Name
Middle Name

Consumer Name: \_\_\_\_\_  

Last Name
First Name
Middle Name

Per the New York State Personal Care Services regulation 18 NYCRR § 505.28 (h)(2), I understand:

- I cannot be paid to work as a Personal Assistant if I am the spouse of the Consumer.
- I cannot be paid to work as a Personal Assistant if I am the parent of a Consumer who is under 21 years of age.
- I cannot be paid to work as a Personal Assistant if I am the Designated Representative of the Consumer.
- I must disclose my relationship to the Consumer to Concepts of Independence, Inc.

**Disclosure**

Do you reside at the same address as the Consumer (Yes/No)? \_\_\_\_\_

Are you related to the Consumer by blood, marriage, or adoption (Yes/No)? \_\_\_\_\_

If you answered yes above, please specify your relationship to the Consumer: \_\_\_\_\_

**Acknowledgment**

I have accurately disclosed my relationship to the Consumer, as indicated above, and agree to the following:

- If my relationship with the Consumer changes, AND/OR if I reside with my Consumer, I will notify Concepts of Independence, Inc. immediately.
- If I fail to disclose my relationship with the Consumer it may be considered Medicaid fraud. As a result, I will repay all wages and salaries erroneously paid to me, plus any applicable fees, penalties, and interest. I am also subject to disciplinary action, up to and including immediate termination of employment.
- If I work for a different Consumer, I will provide a separate relationship disclosure form.

\_\_\_\_\_  

Personal Assistant Signature
Date

\_\_\_\_\_  

Consumer/Designated Representative Signature
Date

Concepts of Independence, Inc. is obligated to report all suspected fraud, abuse, and false claims to the State of New York Office of the Attorney General Medicaid Fraud Control Unit, the Office of the Medicaid Inspector General, and the City of New York for Medicaid fraud investigation.





***Personal Assistant  
 Hepatitis-B Vaccine Form***

Personal Assistant Name: \_\_\_\_\_  
Last Name
First Name
Middle Name

**Declaration**

As a Personal Assistant employed by a participant in Concepts' Consumer Directed Personal Assistance Program, I certify that I have received training from the Consumer. This training has included a discussion of the Hepatitis-B virus, the Hepatitis-B vaccine, and the use of the Universal Precautions that the Consumer deems necessary and appropriate. Also included in this training discussion was information about the process to be followed if a work-related accident occurs, which may have caused an exposure to the Hepatitis-B virus. I have also been informed that the Hepatitis-B vaccine is available at NO COST to all Personal Assistants who wish to receive it.

**NOTE:** For the Hepatitis-B vaccine to protect the Personal Assistant, they must agree to receive three (3) vaccines. The first vaccine will be issued during the first visit to the clinic, the second vaccine will be given one month later, and the third vaccine will be given after an additional five months. If the Personal Assistant misses an appointment, they may have to restart the series of vaccines or receive an additional vaccine.

\_\_\_\_\_  
Personal Assistant Signature
Date

**Hepatitis-B Vaccine Consent/Declination**

I have reviewed and understand the information above. I hereby:

**ACCEPT (Consent):** **YES, I AGREE** to receive the three (3) vaccines for Hepatitis-B at NO COST to me.

- 1<sup>st</sup> Vaccine: Date of Medical Exam
- 2<sup>nd</sup> Vaccine: One (1) Month after the 1<sup>st</sup> Vaccine
- 3<sup>rd</sup> Vaccine: Five (5) Months after the 2<sup>nd</sup> Vaccine

**DECLINE (Waive):** **NO, I DO NOT AGREE** to receive the Hepatitis-B vaccines. I understand that by declining to receive the vaccine(s), I continue to be at risk of acquiring Hepatitis-B, a serious disease.

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis-B Virus (HBV) infection. I understand that I have been given the opportunity to be vaccinated with Hepatitis-B vaccine, at NO CHARGE to me. I also understand that if in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis-B vaccines, I can choose to receive the vaccinations at NO CHARGE to me. By signing below, I certify that I have accepted/declined the Hepatitis-B vaccines as indicated above.

\_\_\_\_\_  
Personal Assistant Signature
Date



*Personal Assistant*  
**Direct Deposit Authorization Form**

Personal Assistants are offered direct deposit to permit Concepts to transfer payroll funds electronically each pay day to a bank/financial institution of choice. The use of direct deposit allows for a secure and timely transfer of payroll funds into your bank account. For this reason, the use of direct deposit is strongly recommended. Please make a selection below:

- YES - I elect to enroll in the use of direct deposit. (Sign below and complete the required bank information.)
- NO - I elect NOT to use direct deposit but I would like to register for a debit card made available by ADP. (Sign below and request the ADP Debit Card Authorization Form.)

\_\_\_\_\_  
 Employee – Personal Assistant Name

\_\_\_\_\_  
 Social Security Number

\_\_\_\_\_  
 Employee – Signature

\_\_\_\_\_  
 Date

If you have elected to enroll in the use of direct deposit (by choosing “yes”), you hereby authorize Concepts of Independence, Inc. and/or Concepts of Independent Choices, Inc. (Concepts) to deposit your net pay automatically to your account specified below. This gives Concepts permission, each pay day, to initiate credit entries of your net pay to your account electronically or by any other commercially accepted method, and authorizes the financial institution named below to credit the same to your account. If funds to which you are not entitled are deposited to your account(s), you give authorization to Concepts to direct the financial institution to return said funds by any such method, and you authorize the financial institution to debit the same to your account(s). This authority will remain in effect until Concepts has received written notice from you of its cancellation in such time and manner as to afford Concepts and the financial institution a reasonable opportunity to act on it.

Bank/Financial Institution Name: \_\_\_\_\_

Account Type:  Checking (please attach a **VOIDED** check)  Savings

Account Number:  
 \_\_\_\_\_

Transit Routing Number (nine digits):  
 \_\_\_\_\_

**If you do not have a check to void, or have a SAVINGS account, please have a bank representative validate the account information entered above and complete the following:**

\_\_\_\_\_  
 Name(s) of Account Holder(s)

\_\_\_\_\_  
 Bank/Financial Institution Name

\_\_\_\_\_  
 Branch Address

\_\_\_\_\_  
 City State Zip Code

\_\_\_\_\_  
 Name of Bank Officer

\_\_\_\_\_  
 Signature of Bank Officer Date



*Personal Assistant*  
**ADP Debit Card Authorization Form**

Personal Assistant Name: \_\_\_\_\_  
Last Name
First Name
Middle Name

I elect to register for the Aline debit card made available by ADP (Automated Date Processing, Inc.) in lieu of using direct deposit transfers directly to my bank/financial institution.

I hereby authorize Concepts of Independence, Inc. to transfer my net payroll amount, or amount indicated in the Aline Enrollment Form, each pay period onto my debit card which will be issued to me by Automated Data Processing, Inc. ("ADP").

\_\_\_\_\_  
 Social Security Number

\_\_\_\_\_  
 ID# (if available)

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

This authorization is to remain in full force and effect until Concepts of Independence, Inc. has received written notification of termination, in a manner specified by Concepts of Independence, Inc. and signed by me. The written notice of termination must be presented to Concepts of Independence, Inc. in such time and manner as to afford Concepts of Independence, Inc. a reasonable amount of time to act upon it.

**This form should not be completed if Direct Deposit services will be used. If so, please proceed to the next section.**



# Enrollment Form

DPS

## Employee Information

Print and Complete All Fields

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_\_

Address \_\_\_\_\_ APT # \_\_\_\_\_  
(P.O. Boxes Not Allowed)

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_

E-mail \_\_\_\_\_

I am requesting  Full amount of my pay loaded to my ALINE Card

I am requesting  Partial amount of \$ \_\_\_\_\_ of my pay loaded to my ALINE Card.

**Please read and sign before submitting:**

By accepting and using my ALINE Card, I agree to be bound by the terms and conditions outlined in the ALINE Cardholder Agreement. I hereby authorize ADP to credit any amounts owed to me, as instructed by my employer, by initiating credit entries to my ALINE Card. In the event that ADP loads funds erroneously to my ALINE Card, I authorize ADP and my employer to debit my card for an amount not to exceed the original amount of the erroneous credit. This authorization is to remain in full force and effect until ADP has received written notice from me of its termination in such time and in such manner as to afford ADP reasonable opportunity to act on it. I agree that I have reviewed, and understand the ALINE Cardholder Fees Summary.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** After completing the form, please return it to your employer.

### FOR EMPLOYER USE ONLY

Tax Branch: \_\_\_\_\_ Company Code: \_\_\_\_\_ Employee ID Number: \_\_\_\_\_

Company Name: \_\_\_\_\_ Employer Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Employer Signature \_\_\_\_\_ Date \_\_\_\_\_

\*ALINE Cards are made available by Automatic Data Processing, Inc.  
The ALINE Card is issued by First California Bank pursuant to a license from Visa U.S.A. Inc. The ADP logo is a registered trademark of ADP, Inc. ALINE is a registered service mark of ADP, Inc. All other trademarks and service marks are the property of their respective owners. T&FSL&D-913-090611



**BENEFICIARY DESIGNATION FORM  
GROUP LIFE, ACCIDENTAL DEATH & DISMEMBERMENT  
CRITICAL ILLNESS AND ACCIDENT INSURANCE**

First Unum Life Insurance Company  
Unum Insurance Company  
Provident Life and Casualty Insurance Company  
The Paul Revere Life Insurance Company

Would you like to enroll in  
the FREE life insurance  
plan offered by Concepts?

Accept

Decline

**Instructions:** Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper. **Return the completed form to your employer.**

**SECTION 1: Employee Information**

Name (Last Name, Suffix, First Name, MI) \_\_\_\_\_ Social Security Number \_\_\_\_\_

Policy Number(s) \_\_\_\_\_ Division Number(s) \_\_\_\_\_  
0226909

Employer Name \_\_\_\_\_  
Concepts of Independence, Inc.  Basic Life  Critical Illness  Accident  
Check the coverages listed below to which this beneficiary designation applies:  
 Supplemental Life  AD&D  All

**SECTION 2: Primary Beneficiary (ies)**

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

1. Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Percentage: \_\_\_\_\_ % (Total must equal 100% between all beneficiaries)

2. Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Percentage: \_\_\_\_\_ % (Total must equal 100% between all beneficiaries)

3. Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Percentage: \_\_\_\_\_ % (Total must equal 100% between all beneficiaries)



**BENEFICIARY DESIGNATION FORM  
GROUP LIFE, ACCIDENTAL DEATH & DISMEMBERMENT  
CRITICAL ILLNESS AND ACCIDENT INSURANCE**

**SECTION 3: Contingent Beneficiary (ies)**

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

1. Name: \_\_\_\_\_  
 Street: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 Percentage: \_\_\_\_\_ % (Total must equal 100% between all beneficiaries)

2. Name: \_\_\_\_\_  
 Street: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 Percentage: \_\_\_\_\_ % (Total must equal 100% between all beneficiaries)

3. Name: \_\_\_\_\_  
 Street: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 Percentage: \_\_\_\_\_ % (Total must equal 100% between all beneficiaries)

**SECTION 4: Signature**

**X** \_\_\_\_\_  
**Employee Signature** **Date**

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

## Employee's Withholding Certificate

OMB No. 1545-0074

**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.**

# 2023

<b>Step 1: Enter Personal Information</b>	<b>(a)</b> First name and middle initial	Last name	<b>(b)</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 <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code		
	<b>(c)</b> <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, other details, and privacy.

**Step 2:  
Multiple Jobs  
or Spouse  
Works**

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

Do **only one** of the following.

**(a)** Reserved for future use.

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

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

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

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

<b>Step 3: Claim Dependent and Other Credits</b>	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 . . . . .	<b>3</b>	\$
<b>Step 4 (optional): Other Adjustments</b>	<b>(a) Other income (not from jobs).</b> 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 . . . . .	<b>4(a)</b>	\$
	<b>(b) Deductions.</b> 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 . . . . .	<b>4(b)</b>	\$
	<b>(c) Extra withholding.</b> Enter any additional tax you want withheld each pay period . . . . .	<b>4(c)</b>	\$

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

<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)  <b>510239824</b>
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# Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

# IT-2104

First name and middle initial	Last name	Your Social Security number
Permanent home address (number and street or rural route)		Apartment number
City, village, or post office		State ZIP code
Are you a resident of New York City? ..... Yes <input type="checkbox"/> No <input type="checkbox"/> Are you a resident of Yonkers? ..... Yes <input type="checkbox"/> No <input type="checkbox"/>		Single or Head of household <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher single rate <input type="checkbox"/> <b>Note:</b> If married but legally separated, mark an <b>X</b> in the <i>Single or Head of household</i> box.
<b>Before making any entries, see the Note below, and if applicable, complete the worksheet in the instructions.</b>		
1 Total number of allowances you are claiming for New York State and Yonkers, if applicable (from line 19, if using worksheet)	1	
2 Total number of allowances for New York City (from line 31, if using worksheet)	2	
<b>Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.</b>		
3 New York State amount	3	
4 New York City amount	4	
5 Yonkers amount	5	

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

**Penalty** – A penalty of \$500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee's signature	Date
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**Employee:** Give this form to your employer and keep a copy for your records. Remember to review this form once a year and update it if needed.

**Note:** Single taxpayers with one job and zero dependents, enter **1** on lines 1 and 2 (if applicable). Married taxpayers with or without dependents, heads of household or taxpayers that expect to itemize deductions or claim tax credits, or both, complete the worksheet in the instructions. Visit [www.tax.ny.gov](http://www.tax.ny.gov) (search: *IT-2104-I*) or scan the QR code below.

**Employer: Keep this certificate with your records.**

If any of the following apply, mark an **X** in each corresponding box, complete the additional information requested, and send an additional copy of this form to New York State. See **Employer** in the instructions. Visit [www.tax.nys.gov](http://www.tax.nys.gov) (search: *IT-2104-I*) or scan the QR code below.

A Employee claimed more than 14 exemption allowances for New York State ..... A

B Employee is a new hire or a rehire ... B  First date employee performed services for pay (mm-dd-yyyy) (see Box B instructions):

You may report new hire information online instead of mailing the form to New York State. Visit [www.nynewhire.com](http://www.nynewhire.com).

**Note:** Employers **must** report individuals under an **independent contractor arrangement** with contracts in excess of \$2,500 using the online reporting website above, **not** Form IT-2104.

Are dependent health insurance benefits available for this employee? ..... Yes  No

If Yes, enter the date the employee qualifies (mm-dd-yyyy):

Employer's name and address (Employer: complete this section only if you are sending a copy of this form to the New York State Tax Department.)	Employer identification number
	510239824



<https://www.tax.ny.gov/r/it2104i-2023>



# Employment Eligibility Verification

## Department of Homeland Security

### U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
OMB No.1615-0047  
Expires 07/31/2026

**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
<p><b>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.</b></p>	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. A noncitizen (other than <b>Item Numbers 2.</b> and <b>3.</b> above) authorized to work until (exp. date, if any)						
If you check <b>Item Number 4.</b> , 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)	<p><b>Additional Information</b></p>    <p>Check here if you used an alternative procedure authorized by DHS to examine documents.</p>				
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)					

<p><b>Certification:</b> 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.</p>		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 <b>Concepts of Independence, Inc.</b>		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.



Notice and Acknowledgement of Pay Rate and Payday Under Section 195.1 of the New York State Labor Law for Home Care Aides Wage Parity and Other Jobs

New York City (NYC)

(English)

1. Employer Information
Consumer:
Last Name First Name
Mailing Address:
Address Apt.
City State Zip Code

2. Notice given:

- At hiring
Before a change in pay rate(s), allowances claimed or payday

Note: Live-in employees must be paid at least 13 hours for each 24-hour period, provided they receive 8 hours of sleep, with five hours of uninterrupted sleep and 3 hours off for meals.

RETURN

- 3. Employee's Rate(s) of Pay for Each Type of Work Shift:
\$ 18.00 per hour for Mon-Fri
\$ 18.50 per hour for Sat-Sun
\$ per hour for

- 3a. Wage Parity Rates:
\$ 18.00 per hour for regular wage
\$ 1.43 per hour for additional wage
\$ 1.81 per hour for supplemental wages\*

- 4. Allowances:
None
Tips per hour
Meals per meal
Lodging
Other

- 5. Regular Payday: Friday

- 6. Pay is:
Weekly
Bi-weekly
Other:

7. Overtime Pay Rate(s) for each type of work or shift:

Single Pay Rate: \$ 27.00 per hour
This must be at least 1 1/2 times the worker's regular rate with few exceptions.

Wage Parity Pay Rate: \$ 27.00 per hour
This must be at least 1 1/2 times the worker's regular rate with few exceptions.

Multiple Pay Rates: \$ per hour
This must be at least 1 1/2 times the worker's Weighted average of the multiple rates of pay for the week, with few exceptions.

- 8. Employee Acknowledgement:
On this date, I have been notified of my pay rate, overtime rate (if eligible), allowances, supplements and designated payday. I told my employer what my primary language is.

Check one:

- I have been given this pay notice in English, because it is my primary language.
My primary language is. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

Employee - Last Name First Name

Employee Signature

Date

Concepts of Independence, Inc. - Fiscal Intermediary
Preparer's Name and Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

Please note: It is unlawful for an employee with protected class status to be paid less than an employee without protected class status, if they are performing substantially equal work. Employers also may not prohibit employees from discussing wages with their co-workers.

\* See Wage Parity supplemental wage(s) notification on page 2.



LS 62 Notice to Wage Parity Home Care Aides - (cont'd)
Benefit Portion of Minimum Rate of Home Care Aide Total Compensation

Table with 5 columns: Supplement Number, Hourly Rate, Type of Supplement, Name & Address of Provider, Agreement/ Plan Information. Rows include Supplement Number 1 (Benefit Card), Supplement Number 2 (Health Insurance), and Supplement Number 3 (Life Insurance/AD&D Supplemental disability).

\*If wage supplements are paid as a single payment owed to multiple Taft-Hartley multiemployer plans, list only the following: (1) the total paid for the supplement or benefit package; (2) the types of benefits included in the package, e.g., pension, health and welfare, or other; (3) the name and address of the entity to whom payment is sent; and (4) the relevant CBA or letter of assent as the agreement.

List any additional benefits and attach listing to this document.

Copies of the above listed agreements or summaries may be obtained by contacting:

Concepts at 212-293-9999 Ext. 209, or Fax 888-418-4014, or email mrobles@coiny.org

Employee Acknowledgement:

On this day I have been notified of my pay rate, overtime rate, allowances, supplements/benefits, and designated payday provided on this form (LS 62) attached, and addendums, on the date given below.

My primary language is \_\_\_\_\_. I have been given this notice in my primary language [ ] Yes [ ] No

Employee Name (Print): \_\_\_\_\_ Last Name First Name

Employee Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Preparer's Name and Title: \_\_\_\_\_ Concepts of Independence, Inc. – Fiscal Intermediary

RETURN