Home Care Specialist's in the Mountains, Inc~ PO Box 2234 ~Franklin, NC 28734~ Phone: (828)349-9500 ~Fax: (828)349-9501

Application Packet

Thank you for applying to Home Care Specialist's in the Mountains, Inc. We need a few things from you before we can complete your application and can start you in your position whether it is within a client's home or within the office. Below you will find a list of the items we need. Please provide these to us as soon as possible.

1. Employment Application: completed in the office or at home
2. Copy of your Social Security card
3. Copy of your valid Driver's License
4. Copy of your Car Insurance Card and Registration
5. Copy of your current CPR card
6. Two (2) copies of fingerprints: To be done at your local sheriff's office.
7. TB skin test: to be done at your local health department or your primary physician's office

This packet included forms that need to be completed fully. These include:

1. Hepatitis B Vaccination declaration form
2. Drug Screen Consent form
3. Blood-born pathogen handout and quiz
4. I-9 Employment Verification form
5. Federal and State tax forms
6. Background Consent form
7. Employee Health History
8. Employee Medication List
9. In-home Aide Policy
10. Appropriate job description(s) based upon the position hired for
11. Confidentiality Policy
12. Medication Policy
13. Direct Deposit form
14. Reference verification forms (2)

Additional forms will be added to your file after you are hired. This is done by the RN Supervisor for Home Care Specialist's in the Mountains, Inc . If there are any questions regarding your packet, the RN Supervisor or Director of the agency will contact you for clarification. Keep all receipts for reimbursement.

Please fill out the entire packet completely and accurately. Anything not completed appropriately will delay the application process. State regulations require that all items listed to be in your file before you can be assigned work. Thank you for your assistance.

DO NOT WRITE BELOW. For Office Use Only.

Last Name _____ Date Hired _____

APPLICATION FOR EMPLOYMENT

(Pre-Employment Questionnaire) (An Equal Opportunity Employer)

PERSONAL INFORMATION

DATE

NAME _____ SOCIAL SECURITY NUMBER _____

LAST FIRST MIDDLE

PRESENT ADDRESS _____

STREET CITY STATE ZIP

PERMANENT ADDRESS _____

STREET CITY STATE ZIP

PHONE NO. ARE YOU 18 YEARS OR OLDER? Yes ☐ No ☐

ARE YOU PREVENTED FROM LAWFULLY BECOMING EMPLOYED IN THIS COUNTRY BECAUSE OF VISA OR IMMIGRATION STATUS? Yes ☐ _____ No ☐ _____

EMPLOYMENT DESIRED

POSITION _____ DATE YOU CAN START _____ SALARY DESIRED _____

ARE YOU EMPLOYED NOW? _____ IF SO MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? _____

EVER APPLIED TO THIS COMPANY BEFORE? _____ WHERE? _____ WHEN? _____

REFERRED BY _____

EDUCATION	NAME AND LOCATION OF SCHOOL	*NO OF YEARS ATTENDED	*DID YOU GRADUATE?	SUBJECTS STUDIED
GRAMMAR SCHOOL				
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL				

GENERAL

SUBJECTS OF SPECIAL STUDY OR RESEARCH WORK _____

SPECIAL SKILLS _____

ACTIVITIES: (CIVIC ATHLETIC ETC.) _____

EXCLUDE ORGANIZATIONS, THE NAME OF WHICH INDICATES THE RACE, CREED, SEX, AGE, MARITAL STATUS, COLOR OR NATION OF ORIGIN OF ITS MEMBERS.

U. S MILITARY OR NAVAL SERVICE _____ RANK _____ PRESENT MEMBERSHIP IN NATIONAL GUARD OR RESERVES _____

*This form has been revised to comply with the provisions of the Americans with Disabilities Act and the final regulations and interpretive guidance promulgated by the EEOC on July 26, 1991.

LAST FIRST MIDDLE

(CONTINUED ON OTHER SIDE)

LITHO IN U.S.A.

FORMER EMPLOYERS (LIST BELOW LAST THREE EMPLOYERS, STARTING WITH LAST ONE FIRST).

DATE MONTH AND YEAR	NAME AND ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM				
TO				
FROM				
TO				
FROM				
TO				
FROM				
TO				

WHICH OF THESE JOBS DID YOU LIKE BEST?

WHAT DID YOU LIKE MOST ABOUT THIS JOB?

REFERENCES: GIVE THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

NAME	ADDRESS	BUSINESS	YEARS ACQUAINTED
1			
2			
3			

THE FOLLOWING STATEMENT APPLIES IN: MARYLAND & MASSACHUSETTS. [Fill in name of state.)
IT IS UNLAWFUL IN THE STATE OF _____ TO REQUIRE OR ADMINISTER A LIE DETECTOR TEST AS A CONDITION OF EMPLOYMENT OR CONTINUED EMPLOYMENT. AN EMPLOYER WHO VIOLATES THIS LAW SHALL BE SUBJECT TO CRIMINAL PENALTIES AND CIVIL LIABILITY.

Signature of Applicant

IN CASE OF EMERGENCY NOTIFY

NAME ADDRESS PHONE NO.

"I CERTIFY THAT ALL THE INFORMATION SUBMITTED BY ME ON THIS APPLICATION IS TRUE AND COMPLETE, AND I UNDERSTAND THAT IF ANY FALSE INFORMATION, OMISSIONS, OR MISREPRESENTATIONS ARE DISCOVERED, MY APPLICATION MAY BE REJECTED AND, IF I AM EMPLOYED. MY EMPLOYMENT MAY BE TERMINATED AT ANY TIME.
IN CONSIDERATION OF MY EMPLOYMENT, I AGREE TO CONFORM TO THE COMPANY'S RULES AND REGULATIONS, AND I AGREE THAT MY EMPLOYMENT AND COMPENSATION CAN BE TERMINATED, WITH OR WITHOUT CAUSE. AND WITH OR WITHOUT NOTICE, AT ANY TIME, AT EITHER MY OR THE COMPANY'S OPTION. I ALSO UNDERSTAND AND AGREE THAT THE TERMS AND CONDITIONS OF MY EMPLOYMENT MAY BE CHANGED, WITH OR WITHOUT CAUSE, AND WITH OR WITHOUT NOTICE, AT ANY TIME BY THE COMPANY. I UNDERSTAND THAT NO COMPANY REPRESENTATIVE, OTHER THAN IT'S PRESIDENT, AND THEN ONLY WHEN IN WRONG AND SIGNED BY THE PRESIDENT, HAS ANY AUTHORITY TO ENTER INTO ANY AGREEMENT FOR EMPLOYMENT FOR ANY SPECIFIC PERIOD OF TIME, OR TO MAKE ANY AGREEMENT CONTRARY TO THE FOREGOING.

DATE SIGNATURE

DO NOT WRITE BELOW THIS LINE

INTERVIEWED BY: DATE:

REMARKS:

NEATNESS ABILITY

HIRED: ☐ Yes ☐ No POSITION DEPT.

SALARY/WAGE DATE REPORTING TO WORK

APPROVED: 1. 2. 3
EMPLOYMENT MANAGER DEPT. HEAD GENERAL MANAGER

Home Care Specialist's in the Mountains, Inc~ PO Box 2234 ~Franklin, NC 28734~ Phone: (828)349-9500 ~Fax: (828)349-9501

Employee's Health Status and Injury History

Name		Date
Emergency Contact	Phone	Relation

Please answer the following medical questions truthfully and comment on any "Yes" answers.

Question	Yes	No	Comment
Reaction to medications			
Skin rashes or eczema			
Back trouble			
Back pain on lifting			
Back injury			
Knee injury			
Back surgery			
Swollen joints			
Rheumatism or arthritis			
Dislocated shoulder			
Fractures			
Any other type of injury			
Do you take any medications? (fill out on Medication List)			
Have you had any workman's comp claims in your past			
Please list any additional medical history not listed above.			

Work-related injury claim(s) in the past 5 years?	Yes	No
If yes, please explain the nature of the injury, date, place of injury, and if you are still being treated for the injury.		

Employee's Signature	Date
RN Signature	Date

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Last Name _____ Date Hired _____

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Medication List

Please list all medications that you are currently taking. This should include all prescription medications, over-the-counter medications (like Advil, Tylenol, etc.), and vitamins/herbals. You do not need to include the directions for the medications, just the name and dosage. Also if there are any changes to this list, please notify the office as soon as possible. Review of medication list will be done at least once a year during annual evaluation. Thanks. **NOTE: If you don't take any medications, write N/A and sign the form.**

Name	Date

Medication	Dosage

Employee's Signature	Date
RN Signature	Date

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Blood Borne Pathogens and Universal Precautions

Workers in many different occupations are at risk of exposure to blood borne pathogens such as HIV, Hepatitis C, and Hepatitis B. In 1991 OSHA issued the blood borne pathogens standard to protect workers form this risk. Training for blood borne pathogens and universal precautions is provided by the employer with training completed during normal working hours.

A blood borne pathogen is a microorganism that is present in human blood and can cause disease in humans. Exposures to blood and other body fluids occur across a wide variety of occupations. Health care workers can be exposed to blood through needle stick and other sharps injuries, mucous membrane, and kin exposures. The pathogens of primary concern are the human immunodeficiency virus (HIV), hepatitis B (HBV), and hepatitis C (HCV). Workers and employers urged to take advantage of available practices to prevent exposure to blood and other body fluids.

Hepatitis B (HBV)

Hepatitis B is caused by a virus tat attacks the liver. A person infected with HBV may exhibit no symptoms at all. The older you are, the more likely you are to exhibit symptoms. Symptoms include nausea, vomiting, fatigue, abdominal pain, loss of appetite, dark urine, clay-colored bowel movements, joint pain and jaundice (yellow skin or yellow tinge to the whites of the eyes). The virus can cause lifelong infection, cirrhosis (scarring) of the liver, liver failure, and death. The person with hepatitis is at risk of developing liver cancer. The only way to know for sure if you have been infected with HBV is through a simple blood test. One out of 20 people will become infected with HBV during their lifetime.

HBV is spread when blood or body fluids from an infected person enters the body of a person who is not infected. For example, HBV is spread through having sex with an infected person without using a condom. HBV is not spread through food or water, sharing eating utensils, breast feeding, hugging, kissing, coughing, sneezing, or by casual contact.

There are antiviral treatments for the treatment of chronic HBV infection. HBV can survive outside the body at least 7 days and still be capable of causing infection. There is a vaccine available to help prevent the disease. A series of three immunizations is given over a six month period. It is recommended that every healthcare worker receive this vaccine at the employer's expense. However, a waiver must be signed by the employee if he/she does not wish to receive the hepatitis B vaccine.

Hepatitis C (HCV)

Hepatitis C is a liver disease caused by the hepatitis C virus (HCV). HCV is found in the blood of people who have been infected with the disease. HCV is spread by direct contact with the blood of an infected person.

HCV is spread primarily by direct contact with human blood. For example, you may have been infected with HCV if:

- You have used street drugs and shared needles with someone who is infected with HCV.
- Received blood or blood products from a donor whose blood contained HCV.
- Were on long-term kidney dialysis and unknowingly shared supplies with someone infected with HCV.
- Were a healthcare worker and had contact with blood on your job, especially accidental needle sticks.

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- Your mother had HCV at the time she gave birth to you.
- Had sex with a person infected with HCV.
- Lived with someone who was infected with HCV and shared things such as a razor or toothbrush.

HCV can live outside the body on an environmental surface at room temperature at least 16 hours but no longer than 4 days. There is no vaccine to prevent HCV. There are several blood tests to determine if you are infected with HCV.

A person can protect themselves from HCV by:

- Never doing drugs and sharing needles.
- Never sharing toothbrushes, razors, and other personal care items.
- If they are a healthcare worker, always follow universal precautions and handle needles safely. Never recap an used needle.
- Consider health risks if getting a tattoo.
- Practice safe sex.

About 2 in 100 healthcare workers will become infected with HCV after a needle stick. Use caution when working with any sharps.

Human Immunodeficiency Virus (HIV)

HIV is a virus that attacks and destroys the immune system. HIV is the virus that causes AIDS (acquired immunodeficiency syndrome). Symptoms of HIV include malaise, fatigue, fever, nausea, loss of appetite, sore throat, swollen lymph glands, and muscle pains. There is no vaccine available at this time to prevent the spread of HIV and only palliative treatment is available after a person has been diagnosed with HIV.

The risk of HIV infection is about 1 in 300. HIV cannot be transmitted through intact skin.

Exposure risk for healthcare workers

Healthcare personnel are at risk for occupational exposure to blood borne pathogens including but not limited to HBV, HCV, and HIV. Exposures occur through needle stick or cuts from other sharp instruments contaminated with an infected patient's blood or through contact of the eye, nose, mouth, or skin with a patient's blood. Important factors that influence the overall risk for occupational exposures include the number of infected individuals in the patient population. Most exposures do not result in infection, but always be safe and use precautions. Many needle sticks and cuts can be prevented by using safer techniques such as never recapping needles, disposing of needles and sharps in puncture resistant containers, and using personal protective equipment (PPE) such as gloves, barriers, etc.). These safety precautions can prevent exposure to contaminated blood and body fluids. Body fluids that can transmit these viruses include blood, semen, vaginal secretions, pleural fluid, saliva, amniotic fluid, cerebrospinal fluid, and human tissue and/or organs.

Exposure

If you are stuck by a needle or other sharp or get blood or body fluids in your eyes, nose, mouth or broken skin, immediately flood the area with water and soap or disinfectant if available. Report the exposure to your

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employer immediately after and seek medical attention per company policy. Prompt reporting is essential.
Universal Precautions

Universal precautions is a practice that treats all blood and body fluids as if they are contaminated with blood borne pathogens. Gloves and protective equipment should be used when there is the slightest possibility that you will be in contact with blood or body fluids. If you must clean up broken glass, use a brush and dust pan or forceps (if available). Do not use your hands to pick up broken glass. Use a mask or face shield if you may be in contact with materials that could splash. If blood or body fluids should get into your eyes, rinse them out immediately and report to your employer. Use gloves to handle dirty laundry or potentially contaminated items. Gowns or aprons may be used for protection also. Never have food or drink in areas that may contain blood or body fluids.

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Blood-born Pathogens Quiz

Name			Date
TRUE	FALSE	Question	
		1. It is the worker's responsibility to seek appropriate training on blood-born pathogens.	
		2. Training is performed during regular working hours.	
		3. The training program must include information on what to do in case of an employee's exposure to blood or body fluids that may be contaminated by blood-born pathogens.	
		4. HIV means hepatitis immunodeficiency.	
		5. HBV means hepatitis B virus.	
		6. HIV can cause AIDS.	
		7. HBV causes liver inflammation.	
		8. Protective equipment such as gloves, masks, and face shields must be provided by the worker at his/her own expense.	
		9. "Universal Precautions" is a plan that treats all blood and body fluids in the work place as if they are contaminated by blood-born pathogens.	
		10. Sweat is a body fluid that the universal precautions plan requires you to treat as contaminated by blood-born pathogens.	
		11. All workers who have routine exposure to blood or other potentially infectious materials should receive the hepatitis B vaccine at the employer's expense.	
		12. The hepatitis B vaccine is given in 3 doses over a 6 month period.	
		13. There is also a vaccine for prevention of HIV infection.	
		14. An employee who is covered under the OSHA blood-born pathogen standard to receive a hepatitis B vaccine may choose to refuse it if he/she signs a decline form.	
		15. Engineering controls and work practice controls go together.	
		16. Drinking coffee is forbidden in areas where there may be exposure to blood-born pathogens.	
		17. Hand washing with soap and warm water is an important example of work practice control.	
		18. You do not need gloves when you are handling dirty laundry.	
		19. If you must clean up broken glass and it may be contaminated by blood-born pathogens, do it by hand as long as you are wearing gloves.	
		20. If you get contaminated blood or body fluids in your eyes, rinse them out with water and report the incident to your employer.	
		21. Hepatitis C does not affect the liver and is curable.	
		22. Hepatitis C is only contracted by direct contact with the person infected by HCV.	
		23. About 2 in 100 healthcare workers will contract HCV in one year after a needle stick.	

Employee's Signature	Date
RN Signature	Date

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In-Home Aide Policy

Please note that these are subject to change. When changes are made, you will need to review and sign the updated policy.

1. Do not make personal phone calls at a client's home.
2. Do not make any long distance calls at a client's home. If you need to reach the office, call 828-349-9500.
3. Do not give your family the client's telephone number. Have them call the office and have a message relayed to you.
4. Take your meals and drinks with you. Do not eat or drink the client's food.
5. Wear scrubs every day. **ABSOLUTELY NO JEANS.**
6. Do not smoke in the client's home. You may smoke outside, but you must pick up your cigarette butts.
7. Please avoid the use of profane language. Things that may not bother you may be very offensive to your client and their family. Please respect this.
8. DO NOT administer (give) medications, eye ointments, etc. to the client. You may assist by handing the bottle to the client only. Ask the RN for clarification if needed.
9. Do not change your time without the approval from Alternative Healthcare (either the Director or RN Supervisor). If you arrive late you cannot work over the allotted time without prior approval first.
10. Turn in time sheets on each Sunday. Time sheets not received on time will be paid on the next pay period.
11. Do not take money from a client for anything other than shopping for them. This means you are not to take money for gas, special tasks that are performed during regular hours or off hours, etc. If you need clarification on this, contact the office.
12. You cannot mow lawns, chop wood, sharpen tools, etc. All work must be related to the client's ADLs as noted on the plan of care. If you need clarification, contact the RN Supervisor.
13. If you are sent to a client's home and someone else is there to perform your duties, do not leave. Call the office first for clarification on what to do or where to go next.
14. **ABSOLUTELY NO CELL PHONES ARE ALLOWED IN THE CLIENT'S HOME WITHOUT PRIOR APPROVAL FIRST.**
15. If you have a PCS client, you may have extra days in a month to take off. You are not allowed to take Monday or Friday off as extra days.

Employee's Signature	Date
RN Signature	Date

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Confidentiality Policy

Every effort will be made to maintain confidentiality of the client and his/her situation. Discussion of the client's condition, home environment, or financial status, family members is strongly discouraged unless it is to notify the office of changes. Discussion of one client with another client or anyone not directly involved in the care of that client is forbidden. Release of information may result in action taken against the employee which may include termination and Federal charges with fines from $ 10,000 to 1 million dollars

I, _____, understand that I must maintain strict confidentiality with all of my clients. I understand that failure to do so will result in disciplinary actions which may include termination of my employment with Home Care Specialist's in the Mountains, Inc.

Employee's Signature	Date
RN Signature	Date

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Medication Policy

Any medications a client is taking cannot at any time be given by an employee unless that employee is a licensed RN or LPN.

CNAs, companions, in-home aides, etc. are not permitted by law to give any type of medication. This includes but is not limited to prescription medications, over-the-counter medications, vitamins, herbals, etc.

If the client is taking medications of any kind and needs complete assistance with taking them, some type of arrangement must be made by the family or responsible party for the medications to be given. If the client takes his/her own medications without assistance or just needs reminders, some type of supervision should be given to ensure that the medications are correctly taken.

This policy must be strictly abided by. State agencies governing home health care enforce the Rules and Regulations strictly. Failure to follow policy will result in disciplinary actions, which may include termination, to be taken.

Employee's Signature	Date
RN Signature	Date

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Consent for Drug Screening

I, _____, am aware that as an employee it is required that I pass a drug screen prior to being hired and that I may be periodically requested to submit to a drug screen throughout my employment with Home Care Specialist's in the Mountains, Inc.

I hereby give my consent for pre-employment drug screening and periodic drug screen requests. I acknowledge that should I refuse or fail a drug screen that my future employment with Home Care Specialist's may be terminated.

Employee's Signature	Date
RN Signature	Date

Initial Drug Screen Performed	
Results	

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Release of Information for Criminal Record Check

Have you ever been convicted of a felony? No____ Yes ____

If yes, please explain:

I authorize the North Carolina Department of Justice through the State Bureau of Investigation Department of Criminal Information to perform a North Carolina criminal record check in connection with my application for employment with Home Care Specialist's in the Mountains, Inc, pursuant to North Carolina General Statute 114-19.3, 131D-40, and/or 131E-255. I also authorized Home Care Specialist's in the Mountains, Inc to perform a national criminal record check.

Print Clearly

Last Name	First Name
Middle Name	Maiden Name
Social Security #	Date of Birth
Sex	Race
Additional Names You Have Used in the Past	

I understand that the North Carolina Bureau of Investigation, Division of Criminal Information, and its officials and employees shall not be held legally accountable in any way for providing this information to Home Care Specialist's in the Mountains, Inc, and I hereby release the agency and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that the health care provider cannot release the results of the criminal history check to me.

Employee's Signature	Date
RN Signature	Date

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Hepatitis B Virus Vaccine Consent or Declination

I understand that due to my occupational exposure to blood and/or other potentially infectious materials I may be at risk of acquiring the Hepatitis B virus (HBV). I have been given the opportunity to be vaccinated with the Hepatitis B vaccine at this time.

_____ I accept the vaccination provided for me by Home Care Specialist's in the Mountains, Inc and will follow the guidelines of the vaccination schedule to insure that I receive each one on time.

_____ I decline receiving this vaccination at this time. I understand that by declining the vaccination I continue to be at risk of acquiring Hepatitis B. If in the future I want to be vaccinated with the Hepatitis B vaccine, I must contact Home Care Specialist's to receive instructions.

_____ I have already received the Hepatitis B vaccination series and have provided/will provide Home Care Specialist's with the documentation of the vaccinations.

Employee's Signature	Date
RN Signature	Date

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Home Care Specialist's in the Mountains, Inc~ PO Box 2234 ~Franklin, NC 28734~ Phone: (828)349-9500 ~Fax: (828)349-9501

Job Description

Position: Field Registered Nurse (RN)

Job Summary

The Field Registered Nurse will provide nursing services to patients at home. RNs assess patients' home environments and instruct patients and their families. They must be able to work independently and may supervise CNAs in the home setting. Field RNs travel to patients' homes, hospitals, assisted independent living facilities and other sites. Nurse may spend considerable time walking and standing. Assess patients and associated needs, develops plan of care for each patient. Field RNs are available on a PRN basis and rotate on-call status.

Qualifications

- Must have graduated from an accredited school of nursing and have a Registered Nurse License within the state of North Carolina
- At least one year of home care experience
- Knowledge of CPR and emergency medical procedures
- Knowledge of drugs and their indications, contraindications, dosing, side effects, and proper administration
- Knowledge of patient evaluation procedures
- Ability to react calmly and effectively in emergency situations
- Ability to maintain quality, safety, and infection control standards
- Knowledge of clinical operations and procedures
- Knowledge of accreditation and certification requirements and standards
- Ability to communicate effectively, both orally and in writing
- Knowledge of patient care charts and patient histories

General Duties and Responsibilities

- Visit new client's home to perform physical and environmental assessments and develop Plan of Care with the client and/or family members. Complete all other documents required to provide in-home hands on service to client. Orient in-home aide to POC as needed.
- Visit clients within 75-90 days to perform aide supervision. Review client status and document any changes to physical assessment, environmental assessment, and POC.
- Evaluate skill level of new hires for in-home aide positions as needed.
- Instruct in-home aide as needed to provide education for unfamiliar tasks i.e. Hoyer lift operation.
- Visit client when necessary to address concerns/issues.
- The field RN will occasionally be requested to cover for the RN supervisor and will be responsible for following the RN Supervisor job description.
- Nurses must be able to work independently and will supervise CNAs and caregivers.
- Receives and records physician orders.
- Performs miscellaneous job-related duties as assigned.
- In addition, the Field RN must follow all regulations in regards to PCS, CAP-DA, CAP-C, and other state regulations applicable to home care agencies.
- Available to work on PRN basis.

Employee's Signature	Date
RN Signature	Date

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Home Care Specialist's in the Mountains, Inc~ PO Box 2234 ~Franklin, NC 28734~ Phone: (828)349-9500 ~Fax: (828)349-9501

Job Description

Position: Licensed Practical Nurse (LPN)

Job Summary

The Licensed Practical Nurse assists the RN Supervisor and Field RN with the supervision of in-home staff on a daily basis in accordance with established standards of practice, agency policy and procedures, and federal and state regulations.

Qualifications

- Must have graduated from an accredited nursing school and must be licensed as a LPN in the state of North Carolina with no substantiated findings against license.
- Must provide two (2) satisfactory references from previous employers.
- Must have at least one (1) year experience in home health care.
- Must have good written and verbal communication skills.
- Must be able to assist the RN with the collection of data and formulation of the plan of care.

General Duties and Responsibilities

The LPN duties are delegated by and performed under the supervision of the RN Supervisor and/or Field RN. Consistent with the client's plan of care, duties may include but are not limited to the following as pursuant to the state board of nursing regulations, established standards of practice, and federal and state regulations:

- Participate in the assessment of the client's health status
- Implement nursing activities as stated on the POC
- Assisting in teaching the client and family members about providing care to the client at home
- Delegate tasks to in-home aides/CNAs and supervising their performance of tasks within the limitations established in state statutes.
- Assist with supervisory and case review visits under the direction of the RN Supervisor and/or Field RN.
- May be requested to fill in as an in-home aide should one be unavailable for duty.

Employee's Signature	Date
RN Signature	Date

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Home Care Specialist's in the Mountains, Inc~ PO Box 2234 ~Franklin, NC 28734~ Phone: (828)349-9500 ~Fax: (828)349-9501

Job Description

Position: Certified Nurse's Aide (CNA)

Job Summary

The Certified Nurse's Aide (CNA) is a paraprofessional member of the health care team who would work directly under the supervision and direction of the field registered nurse (RN) and/or RN Supervisor and provides various services for the client. The majority of which would be personal care and activities of daily living which involve minimal and/or extensive assistance to a client who may be totally dependent in the activity or requires substantial hands on care and physical support including more than guided maneuvering of limbs or weight bearing assistance.

Qualifications

- Must be at least eighteen (18) years of age and have a minimum of a High School Diploma. Home Care Specialist's prefers applicant have at least one year of experience in the healthcare profession. Must be listed on the Nurse Aide I Registry. Applicant must have two (2) satisfactory references from previous employers.
- Must display good emotional health and be able to physically tolerate much standing, bending, stooping, and heavy lifting within guidelines and teaching provided by the state of North Carolina.
- Must be able to read and follow written instructions and **Document** the care that is given.
- The applicant should demonstrate flexibility in acceptance of assignments and a cooperative attitude toward providing services; and must meet all agency requirements.

General Duties and Responsibilities

- Performs under the supervision of a RN who has provided written instructions for client care (Plan of Care)
- Assists client in all activities of daily living/hygiene assistance, bathing, grooming, linen changes, and so forth. (As documented in the Plan of Care)
- Prepares nutritious meals within the client's diet and assists client with eating when necessary.
- Assists clients with transfers, ambulation, and exercises under guidelines of the RN when warranted and documented in POC
- Performs light housekeeping chores, which facilitates client's self-care in the home.
- At no time are you allowed to move furniture, reach into dark areas without light, climb on ladders, spray pesticides, do yard work, remove boxes off of shelves above your head.
- Assists client in bathroom, with the use of the bedpan, and performs incontinence care.
- Answers client's calls and attends to their requests promptly.
- Meets the safety needs of the client and uses equipment safely and properly.
- Completes records and carries out all assignments as required. (Submitting correctly completed timesheets weekly.)
- May not be assigned to receive or reduce to writing orders from a physician.
- Notifies RN Supervisor or Field RN of any acute or pertinent changes in a client's condition.
- Communicates availability to work to the Scheduler and/or Director on a weekly basis or as required.
- Maintains confidentiality regarding the client's condition and his/her family, with the exception of the agency.
- Performs all skills and procedures competently, and within the regulations and licensing laws of the state of NC, other applicable federal and state laws, and agency policies.

This job description represents a list of the duties and responsibilities, and gives examples of the variety and general nature of this position for Certified Nurse's Aide. It is not intended that this description include all duties required to perform this position, nor is it intended that related duties may not be required. Further, the applicant may be assigned a client who requires services which are at the level of companionship and housekeeping only. In that event, the duties *below*, including the non-personal care tasks above will apply:

- Provide only non-personal care to the client
- Provides continuous companionship for the client while on duty
- Assists the client to live in a clean, healthy, and safe environment

DO NOT WRITE BELOW. For Office Use Only.

Last Name _____ Date Hired _____

- Observes the client for general physical, emotional, and mental conditions, and reports all changes in condition.
- Keeps appropriate records of all activity while in the client's home.
- Provides a sense of security for the client and protects the client as much as possible from any harm resulting from the debilitating effects of his or her illness.
- Assists clients as needed, excluding medical care.

Employee's Signature	Date
RN Signature	Date

DO NOT WRITE BELOW. For Office Use Only.

Last Name _____ Date Hired _____

Home Care Specialist's in the Mountains, Inc~ PO Box 2234 ~Franklin, NC 28734~ Phone: (828)349-9500 ~Fax: (828)349-9501

Job Description

Position: In-home Care Aide

Job Summary

The in-home care aide is a member of the health care team who will work directly under the supervision of the registered nurse (RN) and provide various services for the client. The majority of the duties will be assistance with personal care and activities of daily living which involves "Partial" hands on care and physical support with minimal guided maneuvering of limbs or weight bearing assistance.

Qualifications

- Must have worked in health care under supervision of an RN, and developed skills necessary to deliver personal care assistance. Must be at least eighteen (18) years of age and have a minimum of a High School Diploma, unless exceptions are made. Alternative Healthcare prefers the applicant to have at least one year of experience in the healthcare profession and must have two (2) satisfactory references from previous employers.
- Must display good emotional health and be able to physically tolerate much standing, bending, stooping, and heavy lifting within guidelines and teaching provided by the state of North Carolina
- Must be able to read, follow writing instructions, and **Document** the care given.
- Should demonstrate flexibility in acceptance of assignments and a cooperative attitude toward providing services. Must meet all agency requirement.

General Duties and Responsibilities

In-home care aides performs only under the supervision of a RN who has provided written instruction for client care (Home Care Plan).

- Assists client in all activities of daily living/hygiene assistance, bathing, grooming, linen changes, and so forth. (As documented in the Plan of Care)
- Prepares nutritious meals within the client's diet and assists client with eating when necessary.
- Performs light housekeeping chores, which facilitates client's self-care in the home.
- Assists client in bathroom, with the use of the bedpan, and performs incontinence care.
- Answers client's calls and attends to their requests promptly.
- Meets the safety needs of the client and uses equipment safely and properly.
- Completes records and carries out all assignments as required. (Submitting correctly completed timesheets weekly.)
- May not be assigned to receive or reduce to writing orders from a physician.
- Notifies RN Supervisor or Field RN of any acute or pertinent changes in a client's condition.
- Communicates availability to work to the Scheduler and/or Director on a weekly basis or as required.
- Maintains confidentiality regarding the client's condition and his/her family, with the exception of the agency.
- Performs all skills and procedures competently, and within the regulations and licensing laws of the state of NC, other applicable federal and state laws, and agency policies.

This job description represents a list of the duties and responsibilities, and gives examples of the variety and general nature of this position for In-home care aide. It is not intended that this description include all duties required to perform this position, nor is it intended that related duties may not be required. Futher, the applicant may be assigned a client who requires services which are at the level of companionship and housekeeping only. In that event, the duties *below*, including the non-personal care tasks above will apply:

- Provide only non-personal care to the client
- Provides continuous companionship for the client while on duty
- Assists the client to live in a clean, healthy, and safe environment
- Observes the client for general physical, emotional, and mental conditions, and reports all changes in condition.
- Keeps appropriate records of all activity while in the client's home.
- Provides a sense of security for the client and protects the client as much as possible from any harm resulting from the debilitating effects of his or her illness.

DO NOT WRITE BELOW. For Office Use Only.

Last Name _____ Date Hired _____

- Assists clients as needed, excluding medical care.

Employee's Signature	Date
RN Signature	Date

Job Description

DO NOT WRITE BELOW. For Office Use Only.

Last Name _____ Date Hired _____

Home Care Specialist's in the Mountains, Inc~ PO Box 2234 ~Franklin, NC 28734~ Phone: (828)349-9500 ~Fax: (828)349-9501

Position: Companion/Homemaker/Respite Care Worker/Sitter

Job Summary

The Companion is a member of the health care team who performs household tasks and provides supervision and activities that allow the client to remain in the home. The Companion is responsible for observing activities and reporting those observations to the Service Supervisor. She is also expected to engage the client in activities that are of interest to the client. The companion will NEVER provide hands-on care or assistance which involves touching the client.

Qualifications

The applicant must be at least eighteen (18) years old. Must be able to read, write, and follow verbal and written instructions and document the services provided. The applicant must have a minimum of six (6) to twelve (12) months of satisfactory employment experience, must be self-directed, and able to work with minimal supervision. The applicant must have at least two (2) satisfactory references from previous employers, and must comply with all agency policies.

General Duties and Responsibilities

- Provides non-personal care to the client
- Provides continuous companionship for the client while on duty
- Assists with meal planning, purchase of foods, and food preparation
- Washes dishes and cleans kitchen after meals
- Assists the client to live in a clean, healthy, and safe environment
- Observes the client for general physical, emotional, and mental conditions, and reports all changes in condition
- Keeps appropriate records for all activity while in the home of the client
- Provides a sense of security for the client and protects the client as much as possible from any harm resulting from the debilitating effects of his or her illness
- Assists client as needed, excluding medical care
- Communicates availability to work to the scheduler on a weekly basis or as required
- Performs light housekeeping chores, which facilitates self-care for the client in the home setting
- Reports any acute or pertinent changes in the condition of the client to the Service Supervisor.

Employee's Signature	Date
RN Signature	Date

Direct Deposit

DO NOT WRITE BELOW. For Office Use Only.

Last Name _____ Date Hired _____

Home Care Specialist's in the Mountains, Inc~ PO Box 2234 ~Franklin, NC 28734~ Phone: (828)349-9500 ~Fax: (828)349-9501

As an employee of Home Care Specialist's in the Mountains, Inc you have the option of having your pay direct deposited. If you opt to chose this method of payment for your pay, please fill out the form below. Otherwise select check.

Name	Date

I choose the following as my method of payment for my earnings:

Check	Direct Deposit

If opting for direct deposit, please supply the following information.

First Name	Middle Initial	Last Name
Bank Name & Address		
Routing #:	Account #:	
Account Type?	Checking	Savings

Would you like to receive email notification when payment is sent via direct deposit? Yes___ No ___

Email address: _____

I, _____, hereby give Home Care Specialist's in the Mountains, Inc permission to transfer funds into the above listed account for the sole purpose of payroll for services rendered.

Employee's Signature	Date

DO NOT WRITE BELOW. For Office Use Only.

Last Name _____ Date Hired _____

To:_____ From:_____ /
Home Care Specialist's in the Mountains, Inc

Company:_____

REFERENCE Check Release Form

_____ is being considered by Home Care Specialist's in the Mountains, Inc for referrals as a : CNA/IHA to deliver home health care services. We would appreciate your reply to the following information and assure you that all information will be kept confidential.

Consent to Reference Checking:
We want you to know that Home Care Specialist's in the Mountains, Inc will be checking your references as part of our screening process. This may include contacting your former employers, as well as friends, acquaintances and business associates. We may as a series of question about your personal background, work experience, character, education and personality.

After Reading This Policy, Please Indicate Your Agreement By Signing It In The Space Provided:
I have read and fully understand the forgoing and voluntarily consent to allow Home Care Specialist's in the Mountains, Inc. to check my references by contacting any person whom they deem to be an appropriate reference. Questions may be asked about my personal background, work experience, personality, personal habits and education. I understand that any information released by my prior employer will be held in strictest confidence, that it will be viewed only by those involved in the hiring decision, and that neither I nor anyone else not so involved will have the right to see the information.

_____ _____
Employee Signature Date

Dates of Service: From_____ to _____

Position: _____

Duties: _____

Eligible for Rehire? YES or NO

Employment Record	Excellent	Very Good	Average	Poor
Attendance	_____	_____	_____	_____
Dependability	_____	_____	_____	_____
Quality of Work	_____	_____	_____	_____
Cooperativeness	_____	_____	_____	_____

Comments: _____

_____

Signature: _____ Date:_____

RETURN FAX : (828) 349-9501

To:_____ From:_____ /
Home Care Specialist's in the Mountains, Inc

Company:_____

REFERENCE Check Release Form

_____ is being considered by Home Care Specialist's in the Mountains, Inc for referrals as a : CNA/IHA to deliver home health care services. We would appreciate your reply to the following information and assure you that all information will be kept confidential.

Consent to Reference Checking:
We want you to know that Home Care Specialist's in the Mountains, Inc will be checking your references as part of our screening process. This may include contacting your former employers, as well as friends, acquaintances and business associates. We may as a series of question about your personal background, work experience, character, education and personality.

After Reading This Policy, Please Indicate Your Agreement By Signing It In The Space Provided:
I have read and fully understand the forgoing and voluntarily consent to allow Home Care Specialist's in the Mountains, Inc. to check my references by contacting any person whom they deem to be an appropriate reference. Questions may be asked about my personal background, work experience, personality, personal habits and education. I understand that any information released by my prior employer will be held in strictest confidence, that it will be viewed only by those involved in the hiring decision, and that neither I nor anyone else not so involved will have the right to see the information.

_____ _____
Employee Signature Date

Dates of Service: From_____ to _____

Position: _____

Duties: _____

Eligible for Rehire? YES or NO

Employment Record	Excellent	Very Good	Average	Poor
Attendance	_____	_____	_____	_____
Dependability	_____	_____	_____	_____
Quality of Work	_____	_____	_____	_____
Cooperativeness	_____	_____	_____	_____

Comments: _____

_____

Signature: _____ Date:_____

RETURN FAX : (828) 349-9501

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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

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

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

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

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

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

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

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

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

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

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		8. Employment authorization document issued by the Department of Homeland Security
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form W-4 (2018)

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

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

Exemption from withholding. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. *Head of household please note:* Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

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Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

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

Employee's Withholding Allowance Certificate

▶ **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2018

1	Your first name and middle initial	Last name	2 **Your social security number**
	Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
	City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ▶ ☐	
5	Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . .	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2018, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶	7	

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

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

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	10 Employer identification number (EIN)

NCDOR
Web
11-15

NC-4
Employee's Withholding Allowance Certificate

PURPOSE - Complete **Form NC-4, Employee's Withholding Allowance Certificate,** so that your employer can withhold the correct amount of State income tax from your pay. **If you do not provide an NC-4 to your employer, your employer is required to withhold based on single with zero allowances.**

FORM NC-4 EZ - You may use this form if you intend to claim either: exempt status, or the N.C. standard deduction and no tax credits or only the credit for children.

FORM NC-4 NRA - If you are a nonresident alien you must use Form NC-4 NRA.

FORM NC-4 BASIC INSTRUCTIONS - Complete the **Allowance Worksheet.** The worksheet will help you figure the number of withholding allowances you are entitled to claim. The worksheet is provided for employees to adjust their withholding allowances based on N.C. itemized deductions, federal adjustments to income, N.C. additions to federal adjusted gross income, N.C. deductions from federal adjusted gross income, and N.C. tax credits. However, you may claim fewer allowances if you wish to increase the tax withheld during the year. If your withholding allowances decrease, you must file a new NC-4 with your employer within 10 days after the change occurs. Exception: When an individual ceases to be head of household after maintaining the household for the major portion of the year, a new NC-4 is not required until the next year.

TWO OR MORE JOBS - If you have more than one job, figure the total number of allowances you are entitled to claim on all jobs using one Form NC-4 Allowance Worksheet. Your withholding will usually be most accurate when all allowances are claimed on the NC-4 filed for the higher paying job and zero allowances are claimed for the other. You should also refer to the Multiple Jobs Table to determine the additional amount to be withheld on line 2 of Form NC-4 (See Allowance Worksheet).

NONWAGE INCOME - If you have a large amount of nonwage income, such as interest or dividends, you should consider making estimated tax payments using Form NC-40 to avoid underpayment of estimated tax interest. Form NC-40 is available on our website at www.dornc.com under individual income tax forms.

HEAD OF HOUSEHOLD - Generally you may claim head of household status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. Note: "Head of Household" for State tax purposes is the same as for federal tax purposes.

QUALIFYING WIDOW(ER) - You may claim qualifying widow(er) status only if your spouse died in either of the two preceding tax years and you meet the following requirements:

1. Your home is maintained as the main household of a child or stepchild for whom you can claim a federal exemption; and
2. You were entitled to file a joint return with your spouse in the year of your spouse's death.

MARRIED TAXPAYERS - For married taxpayers, both spouses must agree as to whether they will each complete the Allowance Worksheet based on married filing jointly or married filing separately.

- For married taxpayers completing the Allowance Worksheet based on married filing jointly, you will consider the sum of both spouses incomes, adjustments, additions, deductions, and credits on the Allowance Worksheet to determine the number of allowances.
- For married taxpayers completing the worksheet on the basis of married filing separately, each spouse will consider only his or her portion of income, adjustments, additions, deductions, and credits on the Allowance Worksheet to determine the number of allowances.

All NC-4 forms are subject to review by the North Carolina Department of Revenue. Your employer may be required to send this form to the North Carolina Department of Revenue.

CAUTION: If you furnish an employer with an Employee's Withholding Allowance Certificate that contains information which has no reasonable basis and results in a lesser amount of tax being withheld than would have been withheld had you furnished reasonable information, you are subject to a penalty of 50% of the amount not properly withheld.

Cut here and give this certificate to your employer. Keep the top portion for your records.

NC-4
Web
10-14

Employee's Withholding Allowance Certificate
North Carolina Department of Revenue

1. **Total number of allowances you are claiming**
   (Enter zero (0), or the number of allowances from Page 2, line 16 of the NC-4 Allowance Worksheet)

2. **Additional amount, if any, withheld from each pay period** *(Enter whole dollars)* .00

Social Security Number

Marital Status: ○ Single ○ Head of Household ○ Married or Qualifying Widow(er)

First Name *(USE CAPITAL LETTERS FOR YOUR NAME AND ADDRESS)* M.I. Last Name

Address County *(Enter first five letters)*

City State Zip Code *(5 digit)* Country *(If not U.S.)*

Employee's Signature Date

I certify, under penalties provided by law, that I am entitled to the number of withholding allowances claimed on line 1 above.