



**Elara Caring Fiscal Intermediary Services for
CDPAP Consumer Directed Personal Assistant Checklist**

(ver. 1.0)

Name:	_____
Date of Birth:	_____
Consumer Name:	_____
Date:	_____

Step 1: By signing below, I am acknowledging that I have received and read the Consumer Directed Personal Assistant Guide.

Signature: _____ Print Name: _____

Date: _____

Step 2: Complete and return the following documents to one of our conveniently located offices.

Document	Completed	Internal Use Only	
		Reviewed	Initial
<i>Acknowledgement Form Signed</i>	Y / N	Y / N	
<i>Application</i>	Y / N	Y / N	
<i>Hepatitis B Vaccination Status (only 1 box check for Vaccination Status, Form signed and dated)</i>	Y / N	Y / N	
<i>Influenza Form (print name, select 1 box, Form signed and dated)</i>	Y / N	Y / N	
<i>If applicable, Physical with MD Stamp (if within past year)</i>	Y / N	Y / N	
<i>W-4 Form (line 3 & 5 must be completed; Form signed and dated)</i>	Y / N	Y / N	
<i>I-9 Form with appropriate IDs</i>	To be completed at Elara Caring office	1) SIGN BUT DO NOT DATE FORM. 2) INCLUDE COPIES OF VALID, NON-EXPIRED ID.	
		Scheduled Mobile Health (including Drug Test)	Pre-Employment
			Drug Screen Add-on

Brooklyn
145 East 98th Street,
Brooklyn, NY 11212

Bronx
2770 Third Avenue
Bronx, NY 10455

Queens
70-00 Austin Street Forest Hills, NY
11375

Staten Island
120 Stuyvesant Place
Staten Island, NY 10301

Long Island
175 Fulton Avenue
Hempstead, NY
11550



PERSONAL ASSISTANT'S GUIDE TO THE CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

The Consumer Directed Personal Assistance Program (CDPAP) is a statewide Medicaid program that provides an alternative way of receiving home care services. The program allows people who are Medicaid-eligible to have more control over who provides their home care and how it is provided. Consumers enrolled in the CDPAP program are allowed to manage their own care by recruiting, hiring, training, supervising, scheduling and dismissing their own personal assistants. Instead of a home care agency controlling the personal assistants, the Consumer takes on the role of employer for the personal assistants.

By accepting this position, you are agreeing to accept training and supervision at the direction of the Consumer or their designated representative. This guide will help facilitate your participation in the CDPAP program.

WHO IS MY EMPLOYER?

The Consumer is your employer and is responsible for hiring, training, supervising, scheduling and dismissing you.

WHAT ARE MY RESPONSIBILITIES?

As a personal assistant, you are responsible for:

1. Recognizing the authority of the Consumer as your employer and supervisor;
2. Completing all tasks specified in the Consumer's plan of care in a manner that enhances the Consumer's ability to live independently;
3. Respecting the Consumer's person, privacy and property;
4. Authorizing Elara Caring to collect and distribute employment-related information;
5. Complying with applicable policies and practices of Elara Caring.

You may perform any task listed in the Consumer's plan of care. These services may include assisting the Consumer with bathing, dressing, toileting, grooming, house cleaning, cooking, laundry and other related personal functions and other activities such as nursing, transportation, transferring, communication assistance, administration of medications and respite services that assists the Consumer to be functional. However, you are limited to performing only those tasks listed in Consumer's plan of care. You cannot perform other tasks and be paid under the CDPAP program. Also, you cannot perform work for other household members. If you perform a task that benefits other household members, it is okay, as long as the benefit is incidental.

WHAT ARE ELARA CARING'S RESPONSIBILITIES?

As the Fiscal Intermediary, Elara Caring is responsible to:

1. Process payroll, including processing income tax and other required wage withholdings and complying with workers' compensation, disability and unemployment insurance.
2. Pay you the wage established for the hours you worked for the Consumer as indicated on your time sheet.
3. Review time sheets and prepare and submit claims for Medicaid payment.
4. Ensure that your health status is assessed before you start working for the Consumer and annually after that.
5. Maintain your personnel records.
6. Maintain records related to the Consumer.
7. Monitor the ability of the Consumer, or the ability of the consumer's designated representative, if applicable, to fulfill the Consumer's responsibilities under the CDPAP program.



WHAT ARE MY PERSONNEL REQUIREMENTS?

You must complete and submit the following to the Elara Caring prior to starting work for the Consumer:

1. I-9 form;
2. W4 form including the Notice and Acknowledgment of Pay Rate and Payday;
3. Pre-employment physical (and a health assessment annually as required by Department of Health regulations);
4. Proof of immunizations as required by Department of Health regulations.
5. Hepatitis B form. The Consumer will review Hepatitis B vaccination or declination information with you.

Elara Caring will perform a check of any exclusion from providing services under the Medicaid program and the result will be filed in your personnel file.

WHAT ARE TIME SHEETS?

A time sheet is an official weekly record of the hours you worked. You must fill out the time sheets with the time you started work for the Consumer and the time you finished work. Both you and the Consumer must sign and date the form and attest that the time sheets are accurate. Attesting means that you and the Consumer are certifying that the time sheets are accurate. The Consumer will submit the time sheets to Elara Caring each week so you can be paid.

If Elara Caring finds that inaccurate time sheets have been submitted, it may inform the Consumer that it will no longer provide fiscal intermediary services to the Consumer and it might also report the inaccuracies to the Department of Social Services (DSS), Managed Care Organization (MCO) and/or the appropriate governmental authorities. Deliberately completing inaccurate time sheets is considered fraud.

WHEN AND HOW DO I GET PAID?

You will get paid every two weeks. You will get paid only for the hours actually worked and for the tasks authorized by the DSS or MCO. If the hours you work exceed the authorized hours in any week or you perform work not covered by the plan of care, those hours are not CDPAP service hours and will not be paid by the CDPAP program.

If you enroll in direct deposit with Elara Caring, your payroll checks will be directly deposited in your bank account every two weeks. If you are not enrolled in our Direct Deposit program, you will receive a payroll check every two weeks. The payroll checks will be payable to you and will be mailed to the Consumer's home. The Consumer will distribute the payroll check to you.

WILL I BE PAID IF THE CONSUMER IS HOSPITALIZED OR ABSENT FROM HOME?

No. You cannot perform any CDPAP services if the Consumer is hospitalized or admitted to a higher level of care or is otherwise absent from the home. You will only be paid for hours of services provided to the Consumer on the day of admission and the day of discharge, if the authorization is still active. If you perform CDPAP services while the Consumer is absent from the home, those hours are the responsibility of the Consumer.

WHEN AM I ELIGIBLE FOR WORKER'S COMPENSATION?

If you are injured on the job, you may be eligible for Worker's Compensation benefits. You must promptly notify Elara Caring whenever an injury has occurred on the job. We will assist you with the completion of the necessary reporting forms and notify the Workers' Compensation carrier.



WHEN AM I ELIGIBLE FOR DISABILITY INSURANCE?

If you are unable to work for a continued period of time, you may be eligible for statutory disability benefits. You must notify the Consumer and Elara Caring. We will assist you with completion of the necessary reporting forms and notify the disability carrier.

WHEN AM I ELIGIBLE FOR UNEMPLOYMENT INSURANCE?

The Consumer must notify Elara Caring whenever you stop working for the Consumer, regardless of whether you quit or have been dismissed. We will review with the Consumer the circumstances and determine whether you are eligible for unemployment insurance.

WHAT SHOULD I DO IF I SUSPECT FRAUD?

If you suspect fraud by the Consumer or his/her designated representative or are aware of any violations of the Medicaid program rules, you should call Elara Caring immediately at 718.689.1253.



CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

CONSUMER DIRECTED PERSONAL ASSISTANT ACKNOWLEDGMENT FORM

This is to acknowledge that I, _____, am going to work as a
(Name of Personal Assistant)

Consumer directed personal assistant for _____ (the "Consumer") in the
(Name of consumer)

Consumer Directed Personal Assistant Program ("CDPAP"). I understand and agree to the following:

1. The Consumer is my employer and is responsible for my hiring, training, supervision, scheduling, and dismissal.
2. The scope of my job duties is determined by the Consumer in accordance with the Consumer's plan of care.
3. The authorized amount of hours I can work for the Consumer in the CDPAP program is determined by the Managed Care Organization or the Department of Social Services, and is in the Consumer's plan of care. If I work more hours than authorized, payment for those hours is exclusively the responsibility of the Consumer and will not be paid by Medicaid or by the Fiscal Intermediary.
4. If the Consumer is hospitalized, I am not authorized to work for the Consumer under the CDPAP program. If I do work for the Consumer when he/she is hospitalized, payment for those hours is exclusively the responsibility of the Consumer and will not be paid by Medicaid or by the Fiscal Intermediary.
5. I work for the Consumer and not for any other household members. That any benefits received by the other household members must be incidental to the work I perform for the Consumer.
6. The Consumer and the Fiscal Intermediary have agreed to fulfill certain responsibilities as required to participate in the CDPAP program. I agree to complete certain forms and provide information to the Fiscal Intermediary so that the Fiscal Intermediary can meet its obligations to the Consumer.
7. The Fiscal Intermediary acts on behalf of the Consumer solely for payroll and benefits administration.
8. I am responsible to submit complete and accurate signed time sheets to the Fiscal Intermediary for my hours worked. I understand that I may record only the hours I actually worked.
9. I must meet the Fiscal Intermediary's personnel requirements prior to starting work for the Consumer, which includes:
 - a. I-9 form;
 - b. W4 form including the Acknowledgment of Wages;
 - c. Pre-employment physical (and a health assessment annually as required by Department of Health regulations);
 - d. Proof of immunizations as required by Department of Health regulations.
10. The Fiscal Intermediary will perform a check of any exclusion from the Medicaid program and the result will be filed in my personnel file. If I am excluded from participating in any federal health care program, including Medicaid and Medicare, I am not permitted to work or to be paid for working. Additionally, I must advise Elara Caring if I am excluded from the Medicaid program.
11. If I become aware of violations of the rules and regulations of the CDPAP program I must report them to the Fiscal Intermediary immediately.

Consumer Directed Personal Assistant Signature

Date



CONSUMER DIRECTED PERSONAL ASSISTANT APPLICATION

Personal Assistant's Name: _____ Date: _____

Address: _____ Apt.#: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell Phone: _____

Email: _____ Social Security #: _____

EDUCATION

High School Name: _____ City/Town: _____

College Name: _____ City/Town: _____

PROFESSIONAL TRAINING

Name of School	City/Town	Start Date	Graduate Date	Certification/Degree

SKILLS LIST (please check all that apply)

Home Care	<input type="checkbox"/>	Special Diets	<input type="checkbox"/>
Kosher Cooking	<input type="checkbox"/>	Household	<input type="checkbox"/>
Laundry	<input type="checkbox"/>	Maintenance	<input type="checkbox"/>
Denture Care	<input type="checkbox"/>	Bed/Bath	<input type="checkbox"/>
Transfer Techniques	<input type="checkbox"/>	Range of Motion	<input type="checkbox"/>
Foyer Lift	<input type="checkbox"/>	Hoyer Lift	<input type="checkbox"/>
Non-Sterile Dressing	<input type="checkbox"/>	Vital Signs	<input type="checkbox"/>
Urine Testing	<input type="checkbox"/>	Geriatrics	<input type="checkbox"/>
Child Care	<input type="checkbox"/>	Orthopedics	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Patient Teaching	<input type="checkbox"/>
Other: _____			

Do you give permission for a criminal screen to be conducted by the consumer? Yes No

Have you ever been excluded or terminated from participation in any federal health care program or New York Medicaid?
 Yes No

Do you give permission to the consumer to verify any information provided on the application? Yes No

I hereby state that all of the foregoing information I have supplied in this application is a true and complete statement of the facts. False statements contained in this application are cause for immediate dismissal.

Signature: _____ Date: _____



CONSUMER DIRECTED PERSONAL ASSISTANT

VACCINATION REFUSAL/REQUEST FORM

HEPATITIS B VACCINATION STATUS

I am aware of the risks of not being given the hepatitis B vaccination, but choose not to be given the vaccination at this time. I am aware that I may request to be provided the vaccine at a later date.

Signature: _____ Date: _____

I have already received the hepatitis B vaccine series.

Signature: _____ Date: _____

I am requesting to receive the hepatitis B vaccine (complete consent below).

HEPATITIS B VACCINATION CONSENT

I, _____, have been provided with information on the hepatitis B vaccine and have been evaluated by a health professional.

I have had the opportunity to ask questions about the benefits and risks of the hepatitis B vaccination.

I also understand that there is no guarantee that I will become immune and that there is a possibility that I will experience an adverse side effect from the vaccine.

I am NOT allergic to yeast or yeast products.

I am NOT currently immune suppressed, either by disease or medication.

For women: I have been advised that studies have not been conducted to determine the effect of the vaccine on a developing fetus. Therefore, the safety of the hepatitis B vaccine relating to the developing fetus is currently unknown.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____



HEPATITIS B VACCINATION FACT SHEET

THE VACCINE:

Engerix-B (Hepatitis B Vaccine) is a noninfectious recombinant DNA hepatitis B vaccine. Over several studies, at least 90% of the individuals immunized have been seroprotected against HBV. Duration of protection by the vaccine has not been fully defined and is still being studied. However, in one study, 76% of the immunized individuals had titers high enough to be considered immune for 1.5 years after the vaccination.

Persons with immune deficiency problems should obtain a written release from their physician prior to receiving the vaccine. Persons with known allergies to yeast or other components of the vaccine will require a risk/benefit assessment to be performed by their physician to determine if the vaccine can be given.

BENEFITS TO RECIPIENTS:

The hepatitis B vaccine provides protection against acquiring the hepatitis B virus. It is especially recommended to those individuals who have occupational exposure to blood or other potentially infectious materials. Although most people who acquire hepatitis B recover fully, about 10% become chronic carriers of the disease and 1-2% die of fulminant hepatitis. There also has been an association between hepatitis B virus and the development of liver cancer and/or cirrhosis of the liver.

POSSIBLE ADVERSE REACTIONS:

Engerix-B is generally well tolerated. No substances of human origin are used in its manufacture. Adverse reactions, if any, to the vaccines are generally mild, infrequent and transient. As with any vaccine, however, it is possible that expanded commercial use of the vaccine could reveal rare adverse reactions not observed in clinical studies.

The most frequently reported adverse reactions include: injection site soreness, fatigue, weakness, induration, erythema, swelling, fever, headache, and dizziness. Adverse reactions of a more serious nature have been reported, but with a frequency of less than 1% of the immunized population. Adverse reactions reported with incidence of less than 1% of injections in clinical studies are: pain, ecchymosis at the injection site, sweating, malaise, chills, weakness, flushing and tingling, hypotension, influenza-like symptoms, upper respiratory tract illness, nausea, anorexia, abdominal pain/cramps, vomiting, constipation, diarrhea, lymphadenopathy, pain/stiffness in arm, shoulder, or neck arthralgia, myalgia, back pain, rash urticaria, petechiae, pruritus, erythema, somnolence, insomnia, irritability, agitation.

Additional adverse experiences have been reported with the commercial use of Engerix B. Those listed below should serve as alerting information to physicians: anaphylaxis, erythema multiform

including Stevens-Johnson Syndrome, angioedema, arthritis, tachycardia/palpitations; bronchospasm including asthma-like symptoms; abnormal liver function tests, dyspepsia; migraine, syncope, paresis, neuropathy, including hypoesthesia, paresthesia, Guillen-Barre Syndrome and Bell's Palsy, transverse myelitis, optic conjunctivitis, keratitis, visual disturbances, vertigo, tinnitus and earache.

CONTRAINDICATIONS:

Not to be used in persons with a known allergy/hypersensitivity to yeast and/or other components of the vaccine. The vaccine should be administered with caution to any person known to have thrombocytopenia or bleeding disorder. These persons should have the vaccination administered via the subcutaneous versus the intramuscular route.

DOSING SCHEDULES:

Three doses of the hepatitis B vaccine are required to confer immunization against infection. Engerix B is administered on a selected date then again at one-month and at six-months from the date of the first injection.



PREGNANCY, FERTILITY AND LACTATION:

Since animal reproduction studies have not been carried out on "Engerix-B", the vaccine should be given to pregnant women only when clearly indicated. It is also not known whether the vaccine can cause any harm to the fetus when administered to a pregnant woman. It is not known if the vaccine affects fertility. Finally, it is not known if the vaccine is excreted in human breast milk. Because many drugs are excreted in human breast milk, caution should be used when considering administering the vaccine to a nursing mother.

Sources: American Hospital Formulary Drug Information, American Society of Hospital Pharmacists. Bethesda, MD 1991 pp.2025-2032 Morbidity and Mortality Weekly Report: Hepatitis B Virus: A comprehensive Strategy for Elimination Transmission in the U.S. Through Universal Childhood Vaccination. 11/22/91, Vol. 40 RR-13, pg. 10.

Signature

Date



Influenza Acceptance/Declination Statement

Employee Name (Please Print)

Last 4 SS Number

Pin #

I understand that due to my occupational exposure to infectious material, I may be at risk of acquiring a strain of Influenza. I understand that I do have the opportunity to be vaccinated with Influenza vaccine, either on my own or through Elara Caring (at no charge to myself). However, if I decline the Influenza Vaccination at this time I understand that if I would like the vaccination in the future, I must contact Elara Caring's Compliance Department to schedule an appointment. I understand that I can receive the vaccination at no charge to me.

I agree to get the flu vaccination prior to Influenza season.

I decline at this time. I understand that by declining this vaccine, I will be at risk of acquiring a strain of Influenza. I may decide to get vaccinated in the future.

Reason for Declination: _____

Employee Signature

Date

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

2021

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <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, when to use the estimator at www.irs.gov/W4App, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents	If your 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 and enter the total here		3	\$
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$
	(c) Extra withholding. Enter any additional tax you want withheld each pay period .	4(c)	\$

Step 5: Sign Here

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

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

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

General Instructions

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 and you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2021 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2022.

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

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

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

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

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

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

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



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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2021 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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



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

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

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

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

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

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

c Add the amounts from lines 2a and 2b and enter the result on line 2c 2c \$ _____

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

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

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



1 Enter an estimate of your 2021 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income 1 \$ _____

2 Enter: } 2 \$ _____
• \$18,800 if you're head of household
• \$25,100 if you're married filing jointly or qualifying widow(er)
• \$12,550 if you're single or married filing separately

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" 3 \$ _____

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

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

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$190	\$850	\$890	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,100	\$1,870	\$1,870
\$10,000 - 19,999	190	1,190	1,890	2,090	2,220	2,220	2,220	2,220	2,300	3,300	4,070	4,070
\$20,000 - 29,999	850	1,890	2,750	2,950	3,080	3,080	3,080	3,160	4,160	5,160	5,930	5,930
\$30,000 - 39,999	890	2,090	2,950	3,150	3,280	3,280	3,360	4,360	5,360	6,360	7,130	7,130
\$40,000 - 49,999	1,020	2,220	3,080	3,280	3,410	3,490	4,490	5,490	6,490	7,490	8,260	8,260
\$50,000 - 59,999	1,020	2,220	3,080	3,280	3,490	4,490	5,490	6,490	7,490	8,490	9,260	9,260
\$60,000 - 69,999	1,020	2,220	3,080	3,360	4,490	5,490	6,490	7,490	8,490	9,490	10,260	10,260
\$70,000 - 79,999	1,020	2,220	3,160	4,360	5,490	6,490	7,490	8,490	9,490	10,490	11,260	11,260
\$80,000 - 99,999	1,020	3,150	5,010	6,210	7,340	8,340	9,340	10,340	11,340	12,340	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,930	7,130	8,260	9,320	10,520	11,720	12,920	14,120	15,090	15,290
\$150,000 - 239,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,230	16,190	16,400
\$240,000 - 259,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,270	17,040	18,040
\$260,000 - 279,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,870	14,870	16,870	18,640	19,640
\$280,000 - 299,999	2,040	4,440	6,500	7,900	9,230	10,470	12,470	14,470	16,470	18,470	20,240	21,240
\$300,000 - 319,999	2,040	4,440	6,500	7,940	10,070	12,070	14,070	16,070	18,070	20,070	21,840	22,840
\$320,000 - 364,999	2,720	5,920	8,780	10,980	13,110	15,110	17,110	19,110	21,190	23,490	25,560	26,860
\$365,000 - 524,999	2,970	6,470	9,630	12,130	14,560	16,860	19,160	21,460	23,760	26,060	28,130	29,430
\$525,000 and over	3,140	6,840	10,200	12,900	15,530	18,030	20,530	23,030	25,530	28,030	30,300	31,800

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$440	\$940	\$1,020	\$1,020	\$1,410	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040	\$2,040
\$10,000 - 19,999	940	1,540	1,620	2,020	3,020	3,470	3,470	3,470	3,640	3,840	3,840	3,840
\$20,000 - 29,999	1,020	1,620	2,100	3,100	4,100	4,550	4,550	4,720	4,920	5,120	5,120	5,120
\$30,000 - 39,999	1,020	2,020	3,100	4,100	5,100	5,550	5,720	5,920	6,120	6,320	6,320	6,320
\$40,000 - 59,999	1,870	3,470	4,550	5,550	6,690	7,340	7,540	7,740	7,940	8,140	8,150	8,150
\$60,000 - 79,999	1,870	3,470	4,690	5,890	7,090	7,740	7,940	8,140	8,340	8,540	9,190	9,990
\$80,000 - 99,999	2,000	3,810	5,090	6,290	7,490	8,140	8,340	8,540	9,390	10,390	11,190	11,990
\$100,000 - 124,999	2,040	3,840	5,120	6,320	7,520	8,360	9,360	10,360	11,360	12,360	13,410	14,510
\$125,000 - 149,999	2,040	3,840	5,120	6,910	8,910	10,360	11,360	12,450	13,750	15,050	16,160	17,260
\$150,000 - 174,999	2,220	4,830	6,910	8,910	10,910	12,600	13,900	15,200	16,500	17,800	18,910	20,010
\$175,000 - 199,999	2,720	5,320	7,490	9,790	12,090	13,850	15,150	16,450	17,750	19,050	20,150	21,250
\$200,000 - 249,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
\$250,000 - 399,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
\$400,000 - 449,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,910	21,220	22,520
\$450,000 and over	3,140	6,250	8,830	11,330	13,830	15,790	17,290	18,790	20,290	21,790	23,100	24,400

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$820	\$930	\$1,020	\$1,020	\$1,020	\$1,420	\$1,870	\$1,870	\$1,910	\$2,040	\$2,040
\$10,000 - 19,999	820	1,900	2,130	2,220	2,220	2,620	3,620	4,070	4,110	4,310	4,440	4,440
\$20,000 - 29,999	930	2,130	2,360	2,450	2,850	3,850	4,850	5,340	5,540	5,740	5,870	5,870
\$30,000 - 39,999	1,020	2,220	2,450	2,940	3,940	4,940	5,980	6,630	6,830	7,030	7,160	7,160
\$40,000 - 59,999	1,020	2,470	3,700	4,790	5,800	7,000	8,200	8,850	9,050	9,250	9,380	9,380
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,850	11,050	11,250	11,520	12,320
\$80,000 - 99,999	1,880	4,280	5,710	7,000	8,200	9,400	10,600	11,250	11,590	12,590	13,520	14,320
\$100,000 - 124,999	2,040	4,440	5,870	7,160	8,360	9,560	11,240	12,690	13,690	14,690	15,670	16,770
\$125,000 - 149,999	2,040	4,440	5,870	7,240	9,240	11,240	13,240	14,690	15,890	17,190	18,420	19,520
\$150,000 - 174,999	2,040	4,920	7,150	9,240	11,240	13,290	15,590	17,340	18,640	19,940	21,170	22,270
\$175,000 - 199,999	2,720	5,920	8,150	10,440	12,740	15,040	17,340	19,090	20,390	21,690	22,920	24,020
\$200,000 - 249,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
\$250,000 - 349,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
\$350,000 - 449,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,900	25,200
\$450,000 and over	3,140	6,840	9,570	12,160	14,660	17,160	19,660	21,610	23,110	24,610	26,050	27,350



Direct Deposit Enrollment Request Form / Fonzulario de Deposito Directo

Authorization agreement for automatic deposits / Acuerdo de autorizacion para depósitos automáticos

Employer/ Empleador: Elara Caring, 70-00 Austin Street Suite 201, Forest Hills, NY 11375

I authorize ELARA CARING and the financial institution to electronically deposit my net pay to the specified account listed below each pay period. Yo autorizo a ELARA CARING y la institución financiera que se indica abajo, a depositar en forma electrónica mi salario neto a la cuenta especificada en cada día de pago.

You can add up to two accounts checking and / or savings account.
Usted puede agregar su depósito directo a su cuenta de cheques o de ahorros.

ACCOUNT TYPE <i>TIPO DE CUENTA</i>	<input type="checkbox"/> CHECKING <i>CUENTA DE CHEQUES</i>	<input type="checkbox"/> SAVINGS <i>CUENTA DE AHORROS</i>
ACCOUNT NUMBER: <i>NUMERO DE CUENTA:</i>	_____	
ROUTING NUMBER: <i>NUMERO DE TRANS/TO:</i>	_____	
BANK NAME: <i>NOMBRE DE BANCO:</i>	_____	
% of flat rate: _____ <i>Circle if you want this amount to be % or flat rate</i>		

ACCOUNT TYPE <i>TIPO DE CUENTA</i>	<input type="checkbox"/> CHECKING <i>CUENTA DE CHEQUES</i>	<input type="checkbox"/> SAVINGS <i>CUENTA DE AHORROS</i>
ACCOUNT NUMBER: <i>NUMERO DE CUENTA:</i>	_____	
ROUTING NUMBER: <i>NUMERO DE TRANS/TO:</i>	_____	
BANK NAME: <i>NOMBRE DE BANCO:</i>	_____	
% of flat rate: _____ <i>Circle if you want this amount to be % or flat rate</i>		

YOU MUST ATTACH A VOIDED CHECK OR BANK PRINT OUT OR ELSE THIS FORM WILL BE DEEMED INVALID AND WILL NOT BE PROCESSED.

First Name *Primer Nombre* **Last Name(s)** *Apellido(s)*

Address *Dirección* **City** *Ciudad* **State** *Estado* **Zip** *Código postal*

Telephone Number *Numero de telefono* **ID #**

Signature (required) *Firma* **Date** *Fecha*



Notice and Acknowledgement of Pay Rate and Payday
Under Section 195.1 of the New York State Labor Law
Notice for Hourly Rate Employees

1. Employer Information

Name: Elara Caring
in c/o _____

Doing Business As (DBA) Name(s):

FEIN (optional):

Physical Address:

70*-00 Austin Street, Suite
201 Forest Hills, NY 11375

Mailing Address:

Phone: 718-689-1252

3. Employee's rate of pay:

\$ 19.09 per hour

4. Allowances taken:

- None
Tips
Meals
Lodging
Other

5. Regular payday: Friday

6. Pay is:

- Weekly
Bi-weekly
Other

7. Overtime Pay Rate:

\$ 20.25 per hour (This must be at least
1 1/2 times the worker's regular rate with
few exceptions.)

8. Employee Acknowledgement:

On this day I have been notified of my pay
rate, overtime rate (if eligible), allowances,
and designated pay day on the date given
below. 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.

Print Employee Name

Employee Signature

Date

James M. Graff, Director Busines
Solutions

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 to be paid less than an employee
of the opposite sex for equal
work. Employers also may not prohibit
employees from discussing wages with their
co-workers.

2. Notice given:

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



Notice and Acknowledgement of Pay Rate and Payday
Under Section 195.1 of the New York State Labor Law
Notice for Hourly Rate Employees

1. Employer Information

Name: Elara Caring
in c/o _____

Doing Business As (DBA) Name(s):

FEIN (optional):

Physical Address:

70*-00 Austin Street, Suite
201 Forest Hills, NY 11375

Mailing Address:

Phone: 718-689-1252

3. Employee's rate of pay:

\$ 15.22 per hour

4. Allowances taken:

- None (checked)
Tips
Meals
Lodging
Other

5. Regular payday: Friday

6. Pay is:

- Weekly (checked)
Bi-weekly
Other

7. Overtime Pay Rate:

\$ 12.50 per hour (This must be at least
1 1/2 times the worker's regular rate with
few exceptions.)

8. Employee Acknowledgement:

On this day I have been notified of my pay
rate, overtime rate (if eligible), allowances,
and designated pay day on the date given
below. 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.

Print Employee Name

Employee Signature

Date

James M. Graff, Director Busines
Solutions

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 to be paid less than an employee
of the opposite sex for equal
work. Employers also may not prohibit
employees from discussing wages with their
co-workers.

2. Notice given:

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



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):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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. <i>(See instructions)</i>	
<p><i>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.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> QR Code - Section 1 Do Not Write In This Space </div>	

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



Employer Completes Next Page





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		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
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)				

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
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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	LIST B Documents that Establish Identity	LIST C Documents that Establish Employment Authorization
OR	AND	
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (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. 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 	<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.