Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

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

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

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

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

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

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

Queens Homecare Agency， Inc

Provisionary Supervision

NAME: _____ DOE :_____

OBSERVATION KEY: PC = Personal Care NM=Nutritional Management T=Transfer
A=Supervise Ambulation ME=Management of Environment
PS = Phone Survey
SCORE KEY : S= Satisfactory U = Unsatisfactory

	Date of Supervision	Client ID	Observations Made	Score	RN Signature
Week 1					
Week2					
Week 3					
Week 4					
Week 5					
Week 6					
Week 7					
Week 8					
Week 9					
Week10					
Week11					
Week12					

Narrative : (Comments of employee's relationship with patient, treating patient with respect, lateness/absenteeism exhibited by employee tec.)

Week1	Week2
Week3	Week4
Week5	Week6
Week7	Week8
Week9	Week10
Week11	Week12

Queens Homecare Agency， Inc

CRIMINAL BACKGROUDN DISCOSURE

Name of Applicant _____

Position Applying for: [ ] HHA [ ] PCA [ ] Homemaker [ ] Housekeeper

Have you ever been bonded? [ ] Yes [ ] No

Have you ever been refused a bond? [ ] Yes [ ] No

Have you ever been convicted of a crime [ ] Yes [ ] No

If yes, identify below:
[ ] Any Class A felony defined in the Penal law (no time limitation)

[ ] Any Class B or C felony defined in the Penal law occurring within 10 years preceding the date of the criminal record check

Any Class D or E felony listed in :
[ ] Article 120 (Assault) Date:_____

[ ] Article 130 (Sexual Offense) Date:_____

[ ] Article 155 (Larceny) Date:_____

[ ] Article 160 (Robbery) Date:_____

[ ] Article 17B (Diversion of Prescription Medication) Date:_____

[ ] Any crime defined in sections 260.32 or 260.34 Date:_____
(Endangering the welfare of a vulnerable elderly person

[ ] Any comparable offense in any other jurisdiction Date:_____

[ ] Other: Specify: _____Date:_____

[ ] Charged with a crime identified above but not convicted or acquitted of that Crime

This sworn statement disclosing any prior finding of patient or resident abuse or conviction of a crime and listed is complete and true. I understand that if employed, false statements on this form are cause for dismissal.

Signature: _____ Date:_____

NEW YORK STATE DEPARTMENT OF HEALTH

Criminal History Record Check

NEW YORK STATE | Department of Health

DOH CHRC form 102: Acknowledgement and Consent for Fingerprinting and Disclosure of Criminal History Record Information

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

Last Name | First Name | Middle Initial | Maiden Name

Date of Birth (mm/dd/yyyy) | Alias/AKA | Mother's Maiden Name

Mailing Address (street) | City | State | ZIP Code

SECTION 2 – ATTESTATION

1.	I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).
2.	I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
3.	I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary. In accordance with applicable laws, DOH will furnish appropriate summary information to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law. I have been informed that upon receiving notification from DCJS that there is a subsequent pending criminal action or proceeding or conviction, the DOH shall promptly notify an authorized person(s) of a provider of the additional allegation or new conviction.
4.	I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.
5.	I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI. If I believe an error has been made by DCJS for any New York State conviction/charge or the FBI for a non-New York State conviction/charge, I understand that I should notify DCJS and/or the FBI to report and request correction of this error to the addresses below.
	NYS Division of Criminal Justice Services Criminal History Bureau Record Review Unit-5th Floor 4 Tower Place, Albany, NY 12203 (518) 485-7675 — Federal Bureau of Investigation Criminal Justice Information Services (CJIS) Division 1000 Custer Hollow Road, Clarksburg, WV 26306 (304) 625-5590
6.	I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.
7.	I certify to the best of my knowledge and belief that I (check as appropriate): ◯ Have ◯ Have not been convicted of a crime in New York State or any other jurisdiction ◯ Do ◯ Do not have a final finding of patient or resident abuse If you checked either "Have" and/or "Do", please provide a brief explanation. (Optional)
8.	My current mailing or home address is indicated in Section 1 of this form.
9.	I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the re-disclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency in accordance with applicable laws. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own.

Applicant Signature: | Date: ☐☐/☐☐/☐☐☐☐

Name and Signature of Parent or Legal Guardian: (if subject individual is under 18 years of age) | Date: ☐☐/☐☐/☐☐☐☐

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name: | Operating License Number (PFI):

Print Name of Authorized Person: | Title:

Signature of Authorized Person: | Date: ☐☐/☐☐/☐☐☐☐

This form is to be retained by the agency. Do not forward to the DOH CHRC.

NYS DEPARTMENT of HEALTH
Criminal History Record Check Request

Type all information
USE CAPITAL LETTERS

DOH use only. Leave blank

SECTION 1 - SUBJECT INDIVIDUAL

Last 4 digits of Social Security Number * ____ Date of Birth mm/dd/yyyy ____ / ____ / ____

LAST Name

FIRST Name M.I.

Maiden Name

Alias (AKA)

Street Number Apt #

Street Name

City St Zip

Home Phone - - Cell Phone - -

Birth Country/Place Use **USA** for United States of America

Sex Race Height (ft-inch) - Weight (lbs) Hair Eyes

SECTION 2 - AGENCY IDENTIFICATION

___ Nursing Home ___ CHHA ___ LTHHCP PFI# **OR** ___ LHCSA LICENSE #

Full name of Agency where applicant will be working

Authorized Person Last Name

First Name

The subject individual, whose identification I have confirmed, will provide direct care or supervision to individuals receiving care and/or services and is a subject individual concerning whom a criminal history record check is required by law (Article 28-E of the Public Health Law and Section 845-B of the Executive Law). Further, the subject individual is not licensed under Title 8 of the Education Law, or is licensed under such Title but will not be hired in the capacity of a licensed professional. I understand that the results of the criminal history record check will be used solely for purposes authorized by law and I will abide by the confidentiality requirements set forth in law. Informed consent (DOH CHRC Form 102) has been given by the subject individual and is on file.

Signature of AP: Date: ____ / ____ / ____ (MM / DD / YYYY)

27093

*The Authorized Person shall inform the subject individual that disclosure of the Social Security Number (SSN) is voluntary and not mandatory and that it will be used to assist DOH-CHRC Unit in performing criminal history record checks.

QUEENS HOMECARE AGENCY, INC.

2 East Broadway, Suite 802,
New York, NY 10038
(Tel) 917-324-6973 (Fax) 347-368-0618

APPLICATION FOR EMPLOYMENT

(Please print and complete this application in detail)

Queens Homecare Agency an equal opportunity employer and does not because of race, creed, color, sex, marital status, age, national origin, handicap, veteran status, or sexual preference.

Last Name **First Name** **Middle**	**Date Application Filled Out**	
Street Address **City, State, Zip**	**Home Tel Number**	**Cellular Number**
Location/ Hours:	**Date of Birth**	

Emergency Contact:	**Relationship:**	**Telephone:**

Have you ever applied for employment with us? **_____Yes_____No If yes: Month and Year_____**	**Social Security #** **_____**
Apart from absence for religious observance, are you available for full -time work? _____Yes_____No I f not, what hours can you work?	**Have you worked within past 6 months?** **_____Yes _____No**
Are you legally authorized to work in the United State? **__Yes __No** **Pending Approval_____(Please bring proof right away)**	**When will you be available to begin work right away?**
Other special training or skills (languages, machine operation, etc.)	**Referred by:**

EMPLOYMENT (MOST RECENT FIRST)

Company Name:	Telephone:
Address:	Employed (Month and Year) From To
Name of Supervisor:	Weekly or Yearly Pay
Job Title and Description of duties:	Reason for Leaving:
Company Name:	Telephone:
Address:	Employed (Month and Year) From To
Name of Supervisor:	Weekly or Yearly Pay
Job Title and Description of duties:	Reason for Leaving:

WORK AVAILABILITY

DAYS: __ Sun. __ Mon. __ Tues. __ Wed. __ Thur. __ Fri. __ Sat.

TIME: _____ _____ _____ _____ _____ _____ _____

COMMENTS:

_____

_____

_____

_____

I certify that all statements made by me on this application are true and correct to the best of my knowledge and belief, and agree that any misrepresentation, falsification or omission of facts thereon shall be sufficient cause to deny my employment or if employed to justify my dismissal.
I understand that any offer of employment is conditional on my ability to establish eligibility under the Immigration Reform and Control act of 1986.

_____ _____ _____

Applicant Name (Please Print) **Applicant Signature** **Date**

OFFICE USE ONLY

Date of Interview/ Interviewed By:	
Date of Hire:	
First Day of Employment (mm/dd/yyyy):	

Queens Homecare Agency， Inc

Acknowledgement

I, print your name) _____have applied for a position at Queens Homecare Agency

[ ] Release of Information

I authorized Queens Homecare Agency to obtain all necessary information for my employment with the company. I understand that this will include contacting my character references, school and training programs, previous employers and medical providers (such as doctors, labs, etc).

[ ] Attestation

I hereby attest that as a job applicant of Queens Homecare Agency. I have received no special inducements, remuneration or promises thereof to work for Queens Homecare Agency. Understand that I will receive a salary in line with other employees of this company who will have similar experience and job duties. Other Benefits that I may be eligible for will be in accordance to with policies established by Queens Homecare Agency.

[ ] Agreement

I release Queens Homecare Agency of any liability that may occur as a result of my personal negligence or due to wrongful/fraudulent information submitted by me. I understand and agree with all the statements on this form.

Signature: _____ Date_____

Queens Homecare Agency， Inc

HHA ACKNOWLEDGEMETN OF OUTSIDE EMPLOUMENT ATTESTATION FORM

All Queens Homecare Agency personnel are required to follow the Rules of Conduct and avoid actions that result in conflict of interest.

_____ I am currently employed by:

- o another Licensed Home Care Agency
- o another organization, but not a Licensed Home Care Agency.

    - o I work form _____ to _____
      (day of week) (day of week)
    - o My hours are from _____ to _____
    - o My hours of employment with another agency vary and I don't have specific days or hours that I work.

OR

_____ I am NOT currently employed by another Licensed Home Care Agency or any other organization

I am aware that I cannot and will not work for another licensed or certified home care agency, or any other organization, during the same hours that I am assigned to provide home health aide services to a patient of Queens Homecare Agency.

Misrepresentation or falsification of any information may result in disciplinary action or termination. I hereby certify that I have read the above statements and that the information provided in this Acknowledgement Form is true and correct to the best of my knowledge.

Employee name: _____

Employee signature: _____

Date: _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

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

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

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 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), 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 2024 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, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

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. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. 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.

Instead, if you (and your spouse) have a total of only two jobs, you may 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 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. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. 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 2024 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. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

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	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

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	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

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	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

Queens Homecare Agency， Inc

ORIENTATION CHECKLIST

Name: _____ SS# _____ Title: _____

1. Welcome to Queens Homecare Agency — Initial/Date Completed Instruction
   - A. Organization overview _____
2. Employment / Management policies
   - A. Compliance requirement _____
   - B. Meetings, case conferences & In-service _____
   - C. Job description _____
   - D. Employee statement of confidentiality _____
   - E. Personnel policy _____ _____
   - F. Privacy policy _____
   - G. Attendance, punctuality & cancellation policy _____
   - H. Availability _____
   - I. Performance evaluations _____
   - J. Code of conduct _____
   - K. Disciplinary action & termination _____
   - L. Emergency & disaster planning, fire safety _____
   - M. Safety in the work environment _____
   - N. Injuries: reporting incidents & accidents _____
   - O. Sexual Harassment _____
3. Patient Care Management Policies
   - A. Communication skills _____
   - B. The on-call process _____
   - C. In-home folder _____
   - D. Personal care plan & Supervisory visits _____
   - E. Patient emergencies in the home _____
   - F. Death in the home guidelines _____
4. OSHA Orientation In-service & Video
   - A. Personal protective equipment _____
   - B. Infection control, exposures & universal precautions _____
   - C. OSHA blood-borne pathogen standard _____
   - D. Tuberculosis & exposure risk assessment _____
   - E. HIV & confidentiality protection _____
   - F. Disaster preparedness: Fire safety & emergencies _____
   - G. Covid _____

I have read my job description and understand that I will be evaluated based on the performance criteria in my job description.

I acknowledge having completed all of the orientation in service curriculum.

Employee signature: _____ Date: _____

Instructor signature: _____ Date: _____

Queens Homecare Agency， Inc

VERIFICATION OF TRAINING IN STANDARD PRECAUTIONS

I, _____, have been trained and / or in-serviced on the proper techniques for caring for patients with communicable disease. The procedure known as Standard Barrier Precautions has been taught to me through Queens Homecare Agency programs and I am knowledgeable as to proper utilization of supplies needed to handle card for such patients.

My signature below supports this statement.

Employee name: _____

Employee signature：_____

Date: _____

Queens Homecare Agency， Inc

Photo Identification

I,_____ acknowledge the receipt of photo Identification card issued to me by Queens Homecare Agency .

I understand that according to company policies:

[ ] I am required to wear my photo ID at all times when working.

[ ] My failure to comply will result in disciplinary action and possible Termination

[ ] My photo ID is a property of Queens Homecare Agency

[ ] I am required to return it to the company upon termination of employment

Signature:_____ Date:_____

Queens Homecare Agency， Inc

OSHA INFORMATION ACKNOWLEDGEMENT

I have received the OSHA orientation and information and I acknowledge understanding of the following as they should be practiced, in addition to any further policies and procedures, which are to be followed:

- Personal protective equipment
- Infection control, exposures & universal precautions
- OSHA Blood-borne pathogen standard
- Tuberculosis & exposure, risk management
- HIV confidentiality protection
- Disaster preparedness: Fire safety & emergencies
- Covid

Employee name: _____

Employee signature: _____

Date: _____

Instructor name: _____

Instructor signature: _____

Date: _____

Queens Homecare Agency，Inc

ACKNOWLEDGEMENT OF RECEIPT OF THE PRIVACY NOTICE

I, _____, have received Queens Homecare Agency's privacy Notice. My questions regarding this notice have been answered.

I know I can contact Queens Homecare Agency at 646-431-0025 if I have any other questions regarding this form.

Employee signature: _____

Date: _____

Queens Homecare Agency， Inc

STATEMENT OF HIV/CONFIDENTILITY

I, (print your name)_____ understand that as an employee of Queens Homecare Agency; I may have access to patient's health information.

[ ] I am aware that I am required to protect the privacy of such information by law (HIPPA regulations.)

[ ] I agree not make any disclosure of such information without proper authorization.

[ ] I further understand that HIPPA can impose penalties/fines on anyone who improperly uses or disclose protected health information.

In the event that I am aware of my patients HIV status, I cannot disclose this information to any other individual. HIPPA regulations prohibit me from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as permitted by law and may result in fine, jail sentence or both. General authorization for release of medical; information is not sufficient for disclosure if HIV status

[ ] I agree to abide by confidentiality policies of Queens Homecare Agency

[ ] I understand that any noncompliance on my part will result in disciplinary action and possible employment termination.

Signature: _____ Date:_____

Queens Homecare Agency， Inc

Employee Disciplinary Attestation

I _____ having received training on confidentiality and HIPAA regulations attest to fully understanding the responsibilities imposed on me regarding Protected Health Information (PHI). These responsibilities will include the reporting of violations without retaliation. I, further, attest to full knowledge of the disciplinary policies of Queens Homecare Agency, Inc. regarding HIPAA and the actions for violations of these regulations.

_____ _____/_____/_____

Signature **Date**

Queens Homecare Agency，Inc

SEXUAL HARASSMENT POLICY

Queens Homecare Agency's position is that sexual harassment is a form of misconduct that undermines the integrity of the employment realtionship. All employees have the right to work in an environment free from all forms of discrimination and conduct which can be considered harassing, coercive, or disruptive, including sexual harassment.

Sexual harassment is defined as any unwanted physical, verbal or visual sexual advances, requests for sexual favors, and other sexually oriented conduct which is offensive or objectionable to the recipient, including but not limited to epithets; derogatory or suggestive comments; slurs or gestures; and offensive posters, pictures or drawings.

Sexual harassment is not tolerated at Queens Homecare Agency. Any staff member engaging in any of the behavior outlined above will be dealt with severely according to the law.

I have read, understand, and agree with the Queens Homecare Agency's sexual harassment policy.

Signature:_____ Date:_____

Queens Homecare Agency，Inc

RECEIPT OF EMPLOYEE ORIENTATION HANDBOOK

I have received a copy of the Caregiver/Employee Orientation handbook, which outlines the benefits, policies, rules and regulations related to by position. I will read and become familiar with these policies and abide by them during my employment. I understand that any failure on my part to comply with any provision of this guide, now or amended, or any rule or regulation may subject me to disciplinary action. I further recognize that Queens Homecare Agency reserves the right to modify, supplement, amend or delete any of the policies or benefits contained in this guide and to add additional policies without prior notice at any time. I understand I am to direct any questions regarding the policies or the interpretation of these policies to my coordinator.

I understand that the Caregiver/Employee Orientation handbook constitute management guidelines only and are neither to be interpreted as a contract between Queens Homecare Agency and me, nor does it constitute a guarantee that my employment will continue for any specified period of time or end only under certain conditions. I understand that neither this guide nor any other communication by a management representative is in any way intended to create an express or implied contract of employment. I also understand that my employment is voluntarily entered into with no definite period of time and I am free to resign at any time. Similarly, Queens Homecare Agency may terminate my employment at any time, for any reason, with or without cause, where and when it believes it is appropriate.

I understand that I am being employed on a “Per Diem” basis for a Queens Homecare Agency. Queens Homecare Agency does not guarantee any specific hours of work per week.

Employee signature: _____

Date: _____

Queens Homecare Agency， Inc

ACKNOWLEDGMENT OF ORIENTATION

Name：_____ Social Security #:_____

Title：_____ Date of Employment:_____

I acknowledge that I have received orientation to the following:

- Queens Homecare Agency's mission, philosophy and goals
- Queens Homecare Agency's personal policies and procedures and continuous quality improvement
- Queens Homecare Agency's administrative policy and procedure manual
- Patient bill of rights, patient confidentiality, right to respect/privacy/property/complaint process
- HIV confidentiality/HIPAA and advance directives/DNR
- OSHA standards:
  - Occupational exposure to blood-borne/tuberculosis program
  - Epidemiology and symptoms
  - Modes of transmission
  - Engineering controls, work practices and use of protective equipment
  - Hepatitis B Vaccine program
  - Responsibilities and reporting mechanism for exposure incident
  - Universal precautions/standard precautions
  - Infection control practice
- Job description
- Time and activity reports
- Clinical documentation requirements
- Disaster and emergency preparedness/safety policy and procedure/fire safety
- Policies and procedures specific to my job responsibilities
- Inservice and continuing education requirements

I understand that this information is readily accessible as a resource to me. I have been given the opportunity to ask for clarification as necessary and will seek additional clarification from my supervisor as necessary.

I have read the above statements and agree to comply with Queens Homecare Agency's policies and procedures.

Employee Signature: _____

Date: _____

Queens Homecare Agency， Inc

Job Description - Home Health Aide

Reports To: Queens Homecare Agency, Inc. Administrator/Director

POSITION DESCRIPTION:

Provides health care tasks, personal hygiene services, housekeeping tasks and other related support services essential to the patient's health.
Observes, records and reports all changes to supervisor. All HHA's must demonstrate competence in performing the necessary skills and only perform those skills on the plan of care.

In accordance with the New York State Department of Health Matrix of Permissible and Non-Permissible Activities, a home health aide may perform activities, which can only be provided for a patient whose characteristics and case situation meet all of the following criteria:

- the patient is self-directing
- the patient has a need for assistance with the task or activity for routine maintenance of his/her health
- the patient cannot physically perform the task
- the patient has no informal caregiver available to perform the tasks

Furthermore, it should be noted that tasks that are permissible might be taught in the basic training curriculum as an addition to the program on a one to one basis by the home care agency employing the aide. Once an aide has received training in a permissible task and has been evaluated as competent, the aide may perform this task without being retrained in the task.

Tasks, which are permissible under special circumstances, are not routinely taught in a home health aide training program. Since these tasks are complex, each aide must receive training in the exact skill and/or procedure to be performed with each patient. Training and competency evaluation in performance of these tasks is not transferable from patient to patient.

Responsibilities:

1. Performs home management tasks including housekeeping, laundry, shopping and errands.
2. Prepares and serves simple modified diets according to instruction and assists with feeding as necessary.
3. Assists with bathing, dressing and grooming.
4. Assists with toileting, including use of bedpan, commode or toilet.
5. Assists with transfers and ambulation including use of cane, walker, and wheelchair.
6. Assists with medication as specified on plan of care.
7. Provides routine skin care. May assist self-directing patients in applying nonprescription topical medications to skin surface.
8. Measures and records vital signs.

9. Collects routine specimens.
10. Obtains patient's weight.
11. Assist self-directing patients in performing maintenance exercise programs.
12. Cares for male external catheter. Assists with the emptying of indwelling catheter care bag.
13. Assists the self-directing patient with use of oxygen equipment.
14. Assists a self-directing patient with the changing a urinary diversion appliance or dressing when the ostomy is mature and stable.

Qualifications: Education & Experience per NYSCRR 700.2 (15)

- The individual has successfully completed a training program in home health aide services, and has successfully received a minimum of 16 hours of clinical in home supervisions, in addition to:
- one full year of experience in providing home health aide services through a home care agency within three years preceding the effective date of an initial certificate issued.
- successful completion of a competency skills assessment set forth in , §484.36(b) Standard: Competency Evaluation In-Service Training
- A verified home health aide certificate from an approved Home Health Aide Training Program.
- Preferred high school diploma or equivalency.
- 18 years of age or older

Physical Requirements and Working conditions:

Mental Demands: Job involves performing tasks under the direction and supervision of a registered nurse. Work requires adherence to precise procedures and standards involving a high degree of accuracy in observing, recording and reporting data.

Physical Demands Appreciable physical effort or strain. Moderately heavy activity. may include lifting, constant stooping and walking.

Working Environment:
Continuous exposure to various disagreeable physical conditions.

Contacts: Good communication skills required with patients, family and other employees.

Home Health Aide Name: _____

Home Health Aide Signature: _____

Date: _____

Queens Homecare Agency， Inc

TRUE OR FALSE

1. The goal of health related tasks is to maintain, strengthen, improve and safeguard the home and the client.
2. The Plan of Care will tell the Aide exactly what health related task is to be performed.
3. Patient has no food in the home, do you call 911.
4. You wash your hands after you every time you help patient.
5. In order to obtain a sputum specimen from a client, you should stand in front of him.
6. Diabetes is sometimes controlled with diet alone.
7. You should report to your coordinator if your diabetic client is shaky and has blurred vision.
8. Arm exercises are important after a mastectomy.
9. It would be dangerous to smoke a cigarette around a client using oxygen.
10. The skin of obese, elderly, frail or very thin clients needs to be handled gently.

MULTIPLE CHOICES:

1. Which of the following is not a goal for the Agency?
   a. Maintain the elderly at home
   b. Assist the handicapped to be more independent
   c. Provide relief for family members for half a day
   d. Replace family members who have moved away
2. Of the following qualities, which one does not describe an effective Home Care worker?
   a. Reliable and punctual
   b. Take charge as though the client's home is his or her own
   c. Treats clients with dignity
   d. Watches out for unsafe conditions in the client's home
3. A Home Care Worker may have to assist a client to assure safety and security needs. That means he/she might have to do which of the following?
   a. Be sure the client remembers to turn off the iron
   b. Help the client resolve a family argument
   c. Give the client's dog a bath
   d. Read a book to the client
4. In meeting your new client, Frank Rank, you first say:
   a. "Hi frank."
   b. "Hello, Mr. Rank, I'm your new aide."
   c. "Is this 145 Park Street? I'm supposing to work here."
   d. "I hear you need help."

Queens Homecare Agency， Inc

5. Mrs. Sally Winsome, your client, is very cranky and upset today. She has thrown her breakfast on the floor, spit on you and yelled, “get out, get out.” Your best action would be:
   a. Call your supervisor immediately.
   b. Go home
   c. Lock her in the bedroom and finish your work.
   d. Burst into tears and make her feel sorry for you.
6. A good source of Vitamin A is
   a. Corn
   b. Collard greens
   c. Peas
   d. Rice
7. A good way to pick up a heavy object is to :
   a. Bend from the waist; keep legs straight
   b. Stand with feet apart ,bend knees, hold object close to your body
   c. Keep feet close together, bend knees, lean over from waist, pick up object keeping arms straight
8. The elderly are often victims of home accidents because they frequently
   a. Like to explore new things
   b. Have little fear
   c. Have vision and hearing problems
9. Which of the following activities will help prevent accidents in the house?
   a. Keep frequently traveled areas of the house free from clutter
   b. Remove objects from stairways
   c. Make sure stairways and other highly traveled route are well lit
   d. All of these
10. In order to keep germs from spreading you should know which objects might be “dirty” or which objects might be “clean.” Which of the following is “clean”?
    a. A used handkerchief
    b. The floor
    c. Unused bed linens
    d. A used toothbrush

Queens Homecare Agency，Inc

是非题，对的写“T”，错的写“F”

1. 与健康有关的任务是维持、强化、提升和保护病人及其家庭。（　　）
2. 护理计划将告诉护理员有哪些与健康有关的任务需执行。（　　）
3. 当病人家里没有食物了，你就该打电话给 911。（　　）
4. 每次帮病人做完家务后，你都必须要洗手。（　　）
5. 为了帮病人收集痰标本，你必须站在病人前面。（　　）
6. 有时糖尿病可藉由饮食控制。（　　）
7. 当你的糖尿病人出现手抖、视力模糊时，需报告你的指导上司。（　　）
8. 对乳腺切除的病人来说手臂运动时非常重要的。（　　）
9. 病人使用氧气在周围 抽烟时危险的。（　　）
10. 在护理肥胖、老年人、软弱等病人是动作需轻柔。（　　）

选择题

1. 、（　）下列哪一项不是家庭护理的目标？

a、让老年人能留住自己的家里　　b、协助残疾人士更加独立

c、提供家庭成员有半天的喘息的机会　　d、取代家庭里已离家的成员

2. 、（　）下列哪一项不是描述有效率的家庭护理员所该有的特质？

a、可被信赖的和准时的　　b、将病人的家当自己的家用

c、对待病人注意病人的尊严　　d、注意病人家中任何危险的状况

3. 、（　）家庭护理员有可能去协助确保病人安全及被保护的需要，故下列哪一项是护理员必须 去做的？

a、确认病人记得将电熨斗的插头拔掉（关掉）　　b、帮助病人解决其家庭纠纷

c、帮病人的狗洗澡　　d、给病人读书讲故事

4. 、（　）去见你的新病人 Frank Rank，你的第一句话该说：

a、“嗨！Frank”

b、“哈喽，Rank’先生。我是你的新护理员”

c、“这里是公园街 145 号吗？我是被指派来这里工作”

d、“我听说你需要帮忙”

5.（ ）你的病人今天非常暴躁且悲伤，他将早餐扔到地上并向你吐口水，吼说：“滚出去，滚出去”。 你的反应最好是：

a、立刻打电话给上司　　b、回家

c、把他关到房间，然后完成你的工作　　d、嚎啕大哭让他觉得对不起你

6.（ ）vit. A 的最佳食物来源是：

a、玉米　b、芥蓝菜　c、豌豆　d、米饭

7.（ ）抬起重物的最好方法：

a、弯腰维持两腿打直

b、两脚非开站立、弯膝，将重物移近身边

c、双脚合并、弯膝、弯腰向前，双手打直将重物抬起

8.（ ）老年人是家庭意外的主要受害者，因为：

a、喜欢探索新事物

b、有点畏惧

c、有视力和听力的障碍

9.（ ）下列哪些动作可帮助预防家庭意外的发生

a、维持常走动区域的通畅，无杂乱堆积物　　b、维持楼梯的净空

c、维持楼梯面交通道的适当照明　　e、以上全是

10.（ ）为了避免病菌的传播，你必须知道哪些东西是脏，哪些是干净的

a、使用过的手巾　　b、地板

c、没有使用的床单　　d、使用过的牙刷

Queens Homecare Agency， Inc

PARAPROFESSIONAL COMPETENCY/PERFORMANCE REVIEW

◯ Initial/Orientation ◯ Annual ◯ Remediation ◯ Other: _____

Employee Name: _____ Title: _____

Period From: _____ To: _____ SS#: _____

Score: S=Satisfactory N=Unsatisfactory N/A=Not Applicable

Method: O=observation I=In-service T=Testing/written or oral

	TASKS	METHOD	SCORE	DATE	RN	COMMENTS
	Hand-washing					
	Pulse& Respiration and Recording (HHA only)					
	Temperature and Recording (HHA only)					
	Bed Bath					
	Tub Bath					
	Shower					
	Shampoo (Sink, Bed)					
	Nail Care					
	Oral Hygiene / Denture Care					
	Toilet/Commode / Bedpan					
	Assist Ambulation with Device					
	Normal Range of Motion (HHA only)					
	Transfer (Chair / Bed) and Posision					
	Other: Telephony Training					

RN signature: _____

NYS RN License No: _____

Date: _____

Queens Homecare Agency， Inc

HHA WRITTEN COMPETENCY EXAM

Employee Name: _____

Date: _____

Enter answers to the test questions below:

1.		11.	
2.		12.	
3.		13.	
4.		14.	
5.		15.	
6.		16.	
7.		17.	
8.		18.	
9.		19.	
10.		20.	

Passing score 70%

RN Name: _____

RN Signature: _____

Date: _____

Queens Homecare Agency，Inc

Employee Name: _____
Print Name

DRUG TESTING POLICY

DRUG FREE WORKPLACE

Purpose:

To provide guidelines for the maintenance of a drug-free workplace to support and ensure the safety of clients and employees.

Policy:

In order to provide for the health and safety of clients, ***Queens Homecare Agency***, supports and maintains a drug-free working environment. Employees may not be at work under the influence of alcohol or while unlawfully using controlled substance. The unlawful manufacture, distribution, dispensation, possession or use of controlled substances or the use of alcohol, including use in vehicles is prohibited.

(Exception: An employee who possesses or uses a drug authorized by a physician/primary health care provider for the employee's use while on the job, and whose performance is not noticeably impaired will not be considered in violation of this policy. Employees are responsible for asking the prescribing practitioner about any side effects that may influence performance. In the event that the medication may affect performance, the employee is responsible to notify his/her immediate supervisor prior to reposting to work.)

Definition: Controlled substance/drugs include but not limited to narcotics, depressants, stimulants, cannabis, and chemical compound added to federal or state regulations and noted as controlled substance.

Drug Testing:

- All federal, state and local regulations regarding drug testing and monitoring will be followed.

There are two types of drug tests:

Pre-employment testing

- Applicants for employment at Queens Homecare Agency are drug-tested after receiving a final

offer of employment and prior to the beginning work. Applicants are notified at the time of application that testing for drugs is a requirement for employment process. Offers of employment are contingent upon successfully passing a drug test.

Testing for Reasonable Suspicion:

● A drug screen may be ordered by the Director of Patient security, in consultation with the Administrator, when a reasonable suspicion of working under influence exists. Refusal to submit to the testing may result in disciplinary action, up to and including termination.

● A positive drug screen means the verified presence of alcohol or other controlled substances. All positive test results are maintained in a separate, confidential, need-to-know access file.

● Every employee, as a condition of continued employed, is required to immediately notify the Administrator, if they are convicted under federal or state criminal statue whether the act causing the conviction occurred on or off work time.

● Queens Homecare Agency will report information concerning possession distribution or use of any illegal drug to law enforcement officials

I HAVE READ ABD UNDERSTAND THE ABOVE AND WILL COMPLY WITH THIS AGREEMENT

Signature :_____ Date:_____

Queens Homecare Agency， Inc

HEPATITIS B VACCINATION FORM

I, (print your name),_____
that due to my occupational exposure to blood or other potential infectious material, I may be at risk of acquiring Hepatitis B virus (HBV Infection). I have been given the opportunity by Queens Homecare Agency to be vaccinated at no charge.

PLEASE SIGN IN ONE PLACE ONLY

[ ] ***DECLINATION*** OF HEPATITIS B VACCINATION

I do not wish t o be given the HPV vaccine at this time. I understand that by declining this vaccine, I continue o be at risk for acquiring Hepatitis B. I am aware that I may request to be provided with the vaccination at a later time during my employment with this agency.

Signature:_____ Date:_____

[ ] ***REQUEST*** *FOR HEPATITIS B VACCINATION*

I am requesting the Hepatitis B Vaccination. I understand that is a series of shots (initial vaccine, second dose six weeks later, third dose six months after initial vaccination) I also understand that there is no guarantee that I will become immune and there is a possibility that I will become immune and there is a possibility that I will experience and adverse side effect from this vaccine.

I certify that:

[ ] That I am not allergic to yeast or yeast products

[ ] I am not currently immunosuppressed, neither by disease or medication.

Safety of the Hepatitis B Vaccine in Pregnancy is currently unknown

Signature:_____ Date:_____

Queens Homecare Agency， Inc

RUBEOLA IMMUNITY

Employee: _____ SS#:_____

Rubeola Immunity titer/ vaccination is not required for this employee as he/she was born prior to 01/01/1957

Signature :_____ Date:_____

Queens Homecare Agency， Inc

TUBERCULOSIS SCREENING QUESTIONNAIRE

ANNUAL _____

Employee name: _____ SS#: _____

Have you ever had a test for Tuberculosis? Yes_____ No _____

PPD/Mantoux Date: _____ Result: _____

Chest X-Ray Date: _____ Result: _____

Treatment Type: _____

Date of Treatment: _____

Do you currently have any of the following symptoms?

Symptoms	Yes	No	Comments
Weakness	___	___	_____
Fatigue	___	___	_____
Lack of Appetite	___	___	_____
Weight Loss	___	___	_____
Low grade Fever	___	___	_____
Night Sweats	___	___	_____
Flu-Like Symptoms	___	___	_____
Chest Pain	___	___	_____
Shortness of Breath	___	___	_____
Persistent Cough	___	___	_____
Blood Streaked Sputum	___	___	_____
Color of Sputum (circle)	Clear	Yellow	Other: _____

Have you ever been exposed to anyone exhibiting the above signs or symptoms, or someone

Who has had active tuberculosis? Yes: ___ No: ___

If yes, when and to whom were you exposed, and what type, if any, follow up treatment did you receive?

_____

If I should notice any of the above signs or symptoms, I understand that I am to immediately notify my Physician and my Employer.

Employee signature: _____ Date: _____

Queens Homecare Agency， Inc

SEASONAL INFLUENZA VACCINATION

Employee name: _____ Title: _____

VACCINE & TYPE	DATE GIVEN	SITE	LOT #	MFR
INFLUENZA				
TYPE: _____				
TYPE: _____				

Signature of vaccinator: _____

Discipline: ◯ MD ◯ DO ◯ NP ◯ PA ◯ RN NYS License No. _____

I certify that the above individual is exempt from receiving the Influenza Vaccine due to medical contraindications recognized by ACIP:

TIV is contraindicated and should not be administered to persons:

- Known to have anaphylactic hypersensitivity to eggs or the other components of the influenza vaccine unless the recipient has been desensitized. Information about vaccine components is located in package inserts from each manufacturer.
- Persons with moderate to severe acute febrile illness usually should not be vaccinated until their symptoms have abated.
- Moderate or severe acute illness with or without fever is a precaution* for TIV.
- GBS within 6 weeks following a previous dose of influenza vaccine is considered to be a precaution for use of influenza vaccines.

*A precaution is a condition in a recipient that might increase the risk for a serious adverse reaction or that might compromise the ability of the vaccine to produce immunity.

Queens Homecare Agency， Inc

流行性感冒疫苗同意书

- Corporate Flu
- CHOICE Flu
- Elected Official Event
- Patient:_____(Program)
- Employee:_____(Corporation)
- Employee ID#:_____
- Congregate Care

姓氏：_____ 名字：_____ 中间名：_____

门牌号码与街名：_____

城市：_____州：_____邮政区号：_____

出生日期：_____性别：_____

本人已阅读或透过说明了解有关流行感冒疫苗的资讯，本人收到疫苗资讯和病患权利法案，且已抽空阅读。本人有机会针对任何疑问发问并获得满意的答复。

- 本人证明本人已年满 18 岁。
- 你去年是否注射过流行感冒疫苗？是_____否_____
- 本人的医师从未警告过本人切勿接受流行性感冒疫苗注射。
- 就本人所知，本人对鸡蛋或鸡肉制品皆无过敏之症。
- 本人对过去所注射的流行感冒疫苗从未有副作用。
- 本人对肾上腺素无过敏反应（肾上腺素是用于中和流感注射过敏反应的药物）。
- 本人目前没有任何发烧或急性感染的症状。
- 本人从未确诊罹患格林巴利症候群。
- 你是否正在服用可迈丁或其他处方抗凝血剂？是_____否_____
- 你是否对乳胶制品过敏？是_____否_____

若 Medicare Part B 是你的主要保险，保险号：_____（包括所有字母和数字）

本人了解流行性感冒对本人或上方署名人士可能带来的益处和风险（本人为上方署名人士之家长、监护或授权代表）。本人同意本人或上方署名人士接受流行性感冒疫苗注射，若适用并授权予 Medicare 给付相关服务费用，并且同意提供一份该免疫记录给本人的主治医师。

VNSNY 及其相关机构皆遵守州法及联邦法针对病患资讯保密的规定，包括 1996 年的医疗保险流通与责任法案（HIPAA）。

签名：_____日期：_____

For Clinical Use Only	
Site of Injection:	Manufacturer:
Date of Vaccination:	Lot Number:
Nurse Name (Printed):	Nurse signature:

Queens Homecare Agency， Inc

COMPLIANCE EMPLOYEE SCREEN

A Queens Homecare Agency human resources representative has screened the following applicant to determine if they have been excluded or terminated from participation in federal health care programs or New York's Medicaid Program.

Applicant Name: _____

Social Security Number _____

Appears on List: [ ]Yes (CANNOT WORK)
[ ]No (CLEAR FOR WORK)

Date of Initial Check: _____

Completed by: _____

Title: _____

(Confirmation Attached)

Queens Homecare Agency

Declination of Influenza Vaccination
For Health Care Personnel

Employee's Name:_____ Employee's ID#:_____

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.

- **Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients or residents may be present during the influenza season.**

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature:_____ Date:_____

Witness: _____ Date:_____

Direct Deposit of Paycheck

If you wish to set up or transfer direct deposit of your paycheck, you will need to complete this form. The attached a voided check or deposit slip from your bank to this completed direct deposit form and mail it to the Queens Homecare Agency.

I would like my paycheck to be automatically deposit to my bank account according to the instructions below:

EMPLOYER INFORMATION

Employer Name: Queens HomeCare Agency

Employer address: 2 East Broadway 8/F, New York, NY 10038

PERSONAL INFORMATION

Employee Name (Last, First): _____

Employee Address: _____

Employee Social Security #: _____

Employee Phone Number: _____

SELECT A ACCOUNT FOR YOU DEPOSIT

CHECK _____ **SAVING** _____

Bank Name: _____

Bank Routing#: _____

Bank Account#: _____

AUTHORIZATION

I authorize Queens Homecare Agency (employer) to deposit my paychecks directly to my bank account indicated above and make (if necessary) adjustments for my credit made in error to my account. This authority will remain in effect until i have given written notice to terminate this service.

Signature: _____ **Date**: _____

NEW YORK STATE | Department of Labor

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

1. Employer Information

Name:

Doing Business As (DBA) Name(s):

FEIN (optional):

Physical Address:

Mailing Address:

Phone:

2. Notice given:

☐ At hiring

☐ Before a change in pay rate(s), allowances claimed or payday

Note: Live-in employees must be paid at least 13 hours for each 24 hour period, provided they receive 8 hours of sleep, with five hours of uninterrupted sleep and 3 hours off for meals. If an employee does not receive 5 hours of uninterrupted sleep, the employee must be paid for all 8 hours. If the employee does not receive meal periods free from duty, the employee must be paid for all 3 hours designated for meals.

3. Employee's Rate(s) of Pay for Each Type of Work Shift:

$_____ per hour for _____
$_____ per hour for _____
$_____ per hour for _____

3a. Wage Parity Rates:

$_____ per hour for regular wage
$_____ per hour for additional wage
$_____ per hour for supplemental wages*

4. Allowances:

☐ None
☐ Tips _____ per hour
☐ Meals _____ per meal
☐ Lodging _____
☐ Other _____

5. Regular Payday: _____

6. Pay is:

☐ Weekly
☐ Bi-weekly
☐ Other: _____

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

Single Pay Rate: $_____ per hour
This must be at least 1½ times the worker's regular rate with few exceptions.

Wage Parity Pay Rate: $_____ per hour
This must be at least 1½ times the worker's regular rate with few exceptions.

Multiple Pay Rates: $_____ per hour
This must be at least 1½ times the worker's Weighted average of the multiple rates of pay for the week, with few exceptions.

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

Check one:

☐ I have been given this pay notice in English, because it is my primary language.

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

_____
Print Employee Name

_____
Employee Signature

_____
Date

_____
Preparer's Name and Title

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

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

*Attach Wage Parity supplement notification page 2.

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

	Hourly Rate	Type of Supplement	Name & Address of Provider	Agreement/ Plan Information
Supplement Number	*$ XXX*	*(Pension, Welfare, or Other)*	*Insert Name and Address of Company or Organization Providing Benefit*	*Identify plan or agreement that creates the benefit, e.g., Union Local No. 1 Collective Bargaining Agreement or Insurance Company X Benefit Plan*
Supplement Number 1				
Supplement Number 2				
Supplement Number 3				

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

List any additional benefits and attach listing to this document.

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

_____

Employee Acknowledgement:

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

My primary language is _____. I have been given this notice in my primary language ☐ Yes ☐ No.

Employee Name (Print): _____

Employee Signature: _____ Date Signed: _____

Preparer's Name and Title: _____

Queens Homecare Agency， Inc

INSURANCE BENEFITS

I, _____, decline the insurance benefit offered by Queens HomeCare Agency Inc.

Signature: _____ Date:_____

QHA

WAIVER OF EMPLOYER SPONSORED HEALTH INSURANCE COVERAGE

You have the option to waive coverage under the EmblemHealth health plan.

I acknowledge that the Employer, Queens Homecare Agency, Inc., has offered me the opportunity to enroll myself in the EmblemHealth health plan, and I am choosing to decline the coverage. In case in future I would like to enroll myself and employer health insurance coverage, I will let Queens HomeCare Agency know about that in writing.

I understand the consequences of my waiver of coverage**.**

Name of Employee	*Signature of Employee*	*Date*

Queens Homecare Agency
Record of Confirmation for HHA and PA Receiving EVV Fact Sheet

I have received all of materials related with Electronic Visit Verification, or EVV Fact sheet. I understand what is written in the materials and I will adhere to all the material's guidelines.

Name of Home Health Aid: _____

HHA Signature: _____

Date: _____

Queens Homecare Agency

EVV Training Instruction for Caregivers

What is NY Medicaid Electronic Visit Verification Program (EVV):

EVV is a system that may include multiple point-of-care verification technologies, such as telephonic, mobile, and web-based verification inputs. The system electronically verifies the occurrence of home- or community-based service visits, identifying the time that service provision begins and ends to ensure accurate claims disbursement and helping to ensure that beneficiaries who are authorized to receive services get the expected care. EVV is used to:

- Verify visits on a real-time basis, including date, location, type of service, individual(s) providing and receiving services, and duration of service(s)
- Validate hours of work for home health employees
- Eliminate billing data entry mistakes
- Reduce costs related to paper billing and payroll
- Help combat fraud, waste, and abuse

How to submit your visit(s):

Submit Visits by Phone:

1. Call 718-557-9837
2. After the verbal instruction. please press the employee ID 990XXX or 99XXXX for PCA/HHA and 980XXX for CDPAS, press # to confirm the identity
3. If the aide is servicing two mutual members, after confirming the ID, the aide has to listen carefully to the instruction again to find out which member is "1" and which member is "2". Use 1 or 2 to select the corresponding member and press # to confirm the member. (if the members are using two different phones to clock in and out, please skip this step)
4. Press 1 to clock in and 2 to clock out, then # to confirm again.
5. After 2#, please press your 4 digit task codes follow with # to enter and confirm each task. Press 0 to finish the visit.

Submit Visits by Smartphone App:

1. Download "visitingaid" from the app store on a smart phone
2. Allow the GPS tracking location from the phone setting
3. Enter only the last name and DOB as instructed (DOB must be entered in 8 digits format, Ex: 01/01/2021)
4. The app will send you a verification code. Please use the code to log in.
5. A small map will be shown up on the in-app screen with your current location (a dot surrounded by a brown circle).
6. The aide may only see the member's name and the location when one is nearby the member’s home.
7. Press the member

8. Press check in to start working
9. Press check out to finish working
10. Select the tasks that were done for the member. Close the app to finish the visit.

Schedule change and lateness:

For any temporary or permanent schedule changes, please must inform Queens Homecare Agency ahead of time.

For any lateness, please inform Queens Homecare Agency as soon as possible.

If any system error occurs, please submit a timesheet to Queens Homecare Agency.

Queens Homecare Agency Inc.
Aide Performance/Competency Evaluation

Job Level: (check one) HHA _v__ PCA ___

Name: _____ Agency Nurse: _____

Satisfactory = S Unsatisfactory = U

Personal Care	Competency	Method	Date	Competency Post Remediation	Method	Date
Hand Washing						
Assist with Hair Care						
Assist with Nail Care						
Assist with Mouth Care						
Assist with Shaving						
AM Care/PM Care						
Shower/Bed Bath						
Eating/Nutrition						
Knowledge of Modified Diet						
Assist with Meal Preparation						
(circle) Breakfast / Lunch / Dinner						
Continual Help/Cueing with Eating						
Nourishment						
Observe Appetite						
Intermittent Supervision with Eating						
Assist with Feeding						
Assist with Dressing						
Weigh Patient and Record						
Mobility						
Adaptive Device						
Walks with Intermittent Supervision						
Walks with Constraint one-to-one						
Wheels with No Supervision or Assist						
Needs Assistance with Wheelchair						
Transfers to Wheelchair/Commode						
Requires Intermittent Supervision with Transfer						
Requires One Person with Transfer						
Toileting Elimination						
Requires Intermittent/Constant Supervision with Toileting						
Use of Urinal/Commode/Bedpan						
Use of Incontinent Pans						
Record Bowel Movement						
Light Housekeeping						
Straighten Room						
Make Bed						
Do Personal Laundry						
Outside Appointments HHA/PCA Accompanies Patient						
Shopping/Errands for Medication and Food						
Home Health Aide Tasks Only						
Assist with Medications						
Right Person						
Right Medication						
Right Dose						
Right Time						
Right Route						

RN: _____ Date: _____

HHA: _____ Date: _____

Queens Homecare Agency Inc.
Aide Performance/Competency Evaluation

Job Level: (check one) HHA _v__ PCA ___

Name: _____ Agency Nurse: _____

Satisfactory = S Unsatisfactory = U

Personal Care	Competency	Method	Date	Competency Post Remediation	Method	Date
Hand Washing						
Assist with Hair Care						
Assist with Nail Care						
Assist with Mouth Care						
Assist with Shaving						
AM Care/PM Care						
Shower/Bed Bath						
Eating/Nutrition						
Knowledge of Modified Diet						
Assist with Meal Preparation						
(circle) Breakfast / Lunch / Dinner						
Continual Help/Cueing with Eating						
Nourishment						
Observe Appetite						
Intermittent Supervision with Eating						
Assist with Feeding						
Assist with Dressing						
Weigh Patient and Record						
Mobility						
Adaptive Device						
Walks with Intermittent Supervision						
Walks with Constraint one-to-one						
Wheels with No Supervision or Assist						
Needs Assistance with Wheelchair						
Transfers to Wheelchair/Commode						
Requires Intermittent Supervision with Transfer						
Requires One Person with Transfer						
Toileting Elimination						
Requires Intermittent/Constant Supervision with Toileting						
Use of Urinal/Commode/Bedpan						
Use of Incontinent Pans						
Record Bowel Movement						
Light Housekeeping						
Straighten Room						
Make Bed						
Do Personal Laundry						
Outside Appointments HHA/PCA Accompanies Patient						
Shopping/Errands for Medication and Food						
Home Health Aide Tasks Only						
Assist with Medications						
Right Person						
Right Medication						
Right Dose						
Right Time						
Right Route						

RN: _____ Date: _____

HHA: _____ Date: _____