



EMPLOYMENT APPLICATION

NAME OF APPLICANT: _____

NAME OF CLIENT: _____

POSITION APPLYING:	
<input type="checkbox"/> Administration	<input type="checkbox"/> Home Family Care
<input type="checkbox"/> Day Habilitation	<input type="checkbox"/> Direct Care Worker

CHECKLIST:	
Please ensure that everything from the checklist is included when submitting application.	
<input type="checkbox"/> Employment Application	<input type="checkbox"/> Applicant Consent Form
<input type="checkbox"/> Principles of Conduct	<input type="checkbox"/> Applicant Info Sheet for Fingerprinting
<input type="checkbox"/> Code of Conduct	<input type="checkbox"/> Copy of Photo ID and SS Card
<input type="checkbox"/> Hepatitis B Vaccination Status Form	<input type="checkbox"/> Diploma/ Resume
<input type="checkbox"/> Employment Eligibility Verification (I-9)	<input type="checkbox"/> ACA Insurance Offer Letter
<input type="checkbox"/> Statewide Central Register Database Check	<input type="checkbox"/> OPWDD Form 152
<input type="checkbox"/> Form W-4	<input type="checkbox"/> Completed Training Test
<input type="checkbox"/> Withholding Certificate (IT-2104)	<input type="checkbox"/> Training Acknowledgement



INSTRUCTIONS TO COMPLETE EMPLOYMENT APPLICATION

- **Employment Application**
Complete this general application, sign and date.
- **Principles of Coduct**
Read, sign and date.
- **Code of Coduct**
Read, sign and date.
- **Hepatits B Vaccination Status Form**
Choose to mark the choice that best suits you. Sign and date.
- **Employment Eligibility Verification**
Complete this general form, sign and date. See list of acceptable documents.
- **Statewide Central Register Database Check**
List all household members (such as husband and children) and their dates of birth.
Previous addresses should be listed and dated from the past **28 years**. Sign twice.
- **Form W-4**
Complete basic information and sign. Make sure to complete step 3.
- **Employee's Withholding Allowance Certificate (IT-2104)**
Fill in basic information. Use the worksheet to help you complete steps 1-5. Sign and date.
- **Applicant Consent Form for Fingerprinting**
Fill in your basic information, make sure to check off number 7. Sign and date.
- **Applicant Info Sheet for Fingerprinting**
Fill in your basic information for fingerprinting.
- **ACA Insurance Offer Letter**
Check off the option that best applies to you.
- **OPWDD 152**
Complete as instructed, sign and date.

Please note: Fingerprinting appointments will only be scheduled once the application is fully completed.

***All Com Hab, Day Hab, and Respite employees are regular W-2 employees, which means that taxes are being deducted from every paycheck.**



EMPLOYMENT APPLICATION

Name:

Address:

City, state, zip:

Telephone # (including area code):

Cell phone # (including area code):

Maiden name:

Date of birth:

Social security #:

Do you drive? Yes No

Driver license number:

Last place of employment:

List names, address and phone of 3 references:

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION. I UNDERSTAND THAT MISREPRESENTATION OR OMISSION OF FACTS CALLS FOR CAUSE FOR DISMISSAL. FURTHER I UNDERSTAND AND AGREE THAT MY EMPLOYMENT IS NOT FOR A DEFINITIVE PERIOD AND MAY, REGARDLESS OF THE DATE OF PAYMENT OF MY WAGES AND SALARY BE TERMINATED AT ANY TIME WITHOUT PREVIOUS NOTICE. ADDITIONALLY, I THE UNDERSIGNED HEREBY AFFIRM THAT ALL STATEMENTS MADE BY ME IN THIS APPLICATION ARE COMPLETELY TRUE.

Signature:

Date:

PRINCIPLES OF CONDUCT

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1. There should be no use of corporal punishment upon clients.

 2. Employees should not engage in any activity that constitutes abuse of clients as defined in the regulations of the commissioner.

 3. Employees should not model inappropriate or unacceptable behavior to a client.

 4. Employees should treat client's information as confidential and utilize such information in a professional manner at all times.

 5. There should be no discriminatory activity against clients or others for any reason, including race, national origin, creed, age, sex, ethnic background, developmental disability or other handicap.

 6. Employees should not distribute, sell, possess, purchase or consume illegal substance or alcohol while at the work place or while performing in a work related capacity.

 7. Employees should not work if their ability to perform their job is impaired due to the use of alcohol, a controlled substance, an illegal substance, or prescribed medication.

 8. Clients should not carry out the duties of providers unless such tasks are described in the client's plan of services by the clients program planning team for the purpose of increasing the client's skills.

 9. Clients should not be subjected to inappropriate firearms or other weapons in or on the grounds of the client's residence.

 10. There should be no financial transaction between providers and clients, which may construe as client exploitation or result in greater benefit to provider than the client.

I have read the principles of conduct for working in this program and understand that a failure to comply with these principles may cause for immediate suspension of my employment.

Signature:

Date:

CODE OF CONDUCT FOR CUSTODIANS OF PEOPLE WITH SPECIAL NEEDS

Introduction

The Code of Conduct, as set forth in the Code of Conduct itself, sets forth a framework intended to assist impacted employees to help people with special needs "live self-directed, meaningful lives in their communities, free from abuse and neglect, and protected from harm," in addition to the specific guidance provided by the agency's policies and training.

Similarly, the Notice to Mandated Reporters contains guidance designed to assist mandated reporters, and is intended to provide a summary of reporting obligations for mandated reporters. It is not intended to supplement or in any way add to the reporting obligations provided by law, rule, or regulation.

As provided by law, rule, or regulation, only custodians who have or will have regular and direct contact with vulnerable persons receiving services or support from facilities or providers covered by the *Justice Center Act* must sign that they have read and understand the Code of Conduct.

The framework provides:

1. Person-Centered Approach

My primary duty is to the people who receive supports and services from this organization. I acknowledge that each person of suitable age must have the opportunity to direct his or her own life, honoring, where consistent with agency policy, their right to assume risk in a safe manner, and recognizing each person's potential for lifelong learning and growth. I understand that my job will require flexibility, creativity and commitment. Whenever consistent with agency policy, I will work to support the individual's preferences and interests.

2. Physical, Emotional and Personal Well-being

I will promote the physical, emotional and personal well-being of any person who receives services and supports from this organization, including their protection from abuse and neglect and reducing their risk of harm to others and themselves.

3. Respect, Dignity and Choice

I will respect the dignity and individuality of any person who receives services and supports from this organization and honor their choices and preferences whenever possible and consistent with agency policy. I will help people receiving supports and services use the opportunities and resources available to all in the community, whenever possible and consistent with agency policy.

4. Self-Determination

I will help people receiving supports and services realize their rights and responsibilities, and, as consistent with agency policy, make informed decisions and understand their options related to their physical health and emotional well-being.

5. Relationships

I will help people who receive services and supports from this organization maintain or develop healthy relationships with family and friends. I will support them in making informed choices about safely expressing their sexuality and other preferences, whenever possible and consistent with agency policy.

6. Advocacy

I will advocate for justice, inclusion and community participation with, or on behalf of, any person who receives services and supports from this organization, as consistent with agency policy. I will promote justice, fairness and equality, and respect their human, civil and legal rights.

7. Personal Health Information and Confidentiality

I understand that persons served by my organization have the right to privacy and confidentiality with respect to their personal health information and I will protect this information from unauthorized use or disclosure, except as required or permitted by law, rule, or regulation.

8. Non-Discrimination

I will not discriminate against people receiving services and supports or colleagues based on race, religion, national origin, sex, age, sexual orientation, economic condition or disability.

9. Integrity, Responsibility and Professional Competency

I will reinforce the values of this organization when it does not compromise the well-being of any person who receives services and supports. I will maintain my skills and competency through continued learning, including all training provided by this organization. I will actively seek advice and guidance of others whenever I am uncertain about an appropriate course of action. I will not misrepresent my professional qualifications or affiliations. I will demonstrate model behavior to all, including persons receiving services and supports.

10. Reporting Requirement

As a mandated reporter, I acknowledge my legal obligation under *Social Services Law* § 491, as may be amended from time to time or superseded, to report all allegations of reportable incidents immediately upon discovery to the Justice Center's Vulnerable Persons' Central Register by calling 1-855-373-2122.

CODE OF CONDUCT¹ ACKNOWLEDGMENT FOR CUSTODIANS OF PEOPLE WITH SPECIAL NEEDS

I pledge to prevent abuse, neglect, or harm toward any person with special needs, consistent with agency policy. In addition, to the extent I am required to report abuse, neglect, or harm of any person with special needs by law, rule, or regulation, I agree to abide by the law, rule, or regulation. If I learn of, or witness, any incident of abuse, neglect or harm toward any person with special needs, I will offer immediate assistance, notify emergency personnel, including 9-1-1, and inform the management of this organization, consistent with agency policy.

I acknowledge that I have read and that I understand the Code of Conduct.

Signature _____ Print Name _____ Date _____

Program: _____ Department: _____ Facility/Provider Organization: Rayim of Hudson Valley Inc.

¹ No aspect of this Code of Conduct is in any way intended to interfere, abridge, or infringe upon the rights provided by the *Taylor Law*.



Hepatitis B Vaccination Status Form

Name:	
Date of Birth:	
Social Security Number:	

This form is to be signed by all covered individuals who are at risk for occupational exposure to blood or potentially infectious materials.

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection.

<input type="checkbox"/> I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.
<input type="checkbox"/> I decline Hepatitis B vaccination at this time because I have previously completed the vaccination series on ____/____/____.

Signature:	Date: / /
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Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

▶ **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>	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee	Today's Date (mm/dd/yyyy)
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Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code

STOP Employer Completes Next Page **STOP**



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

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
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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)				

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 <i>Simic Lov</i>		Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative HR Coordinator	
Last Name of Employer or Authorized Representative Lev		First Name of Employer or Authorized Representative Simi		Employer's Business or Organization Name Rayim of Hudson Valley, Inc.
Employer's Business or Organization Address (Street Number and Name) 2 Van Buren Dr. #101			City or Town Monroe	State NY
				ZIP Code 10950

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

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

Refer to the instructions for more information about acceptable receipts.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STATEWIDE CENTRAL REGISTER DATABASE CHECK
Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code): () -
PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:			The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form <u>FOR ALL CATEGORIES:</u> Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS/MARRIAGE SECTIONS THAT APPLY. IF NONE, STATE "NONE" List RELATIONSHIP in the fields below <i>(see reverse side for instructions) Attach additional page if necessary.</i>	
AGENCY NAME: _____				
AGENCY LIAISON: _____				
STREET ADDRESS: _____				
CITY: _____	STATE: _____	ZIP CODE: _____		

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA

***PLEASE TYPE OR PRINT CLEARLY**

IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK THIS BOX.

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH
APPLICANT				
APPLICANT MAIDEN/ALIAS/MARRIED NAME				

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr)	TO (Mo/Yr)
					/	/
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	/	/
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	/	/
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	/	/
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	/	/

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE / /
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APPLICANT'S SIGNATURE	DATE / /
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EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen-years of age or over in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE / /
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SIGNATURE	DATE / /
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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.**

2020

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 online estimator, 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 2020 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 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)
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Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

First name and middle initial	Last name	Your Social Security number
Permanent home address (number and street or rural route)		Apartment number
City, village, or post office		State ZIP code
Single or Head of household <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher single rate <input type="checkbox"/> Note: If married but legally separated, mark an X in the <i>Single or Head of household</i> box.		
Are you a resident of New York City? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you a resident of Yonkers? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Complete the worksheet on page 4 before making any entries.		
1 Total number of allowances you are claiming for New York State and Yonkers, if applicable (from line 20)	1	
2 Total number of allowances for New York City (from line 35)	2	
Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.		
3 New York State amount	3	
4 New York City amount	4	
5 Yonkers amount	5	

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

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

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: Keep this certificate with your records.

Mark an **X** in box A and/or box B to indicate why you are sending a copy of this form to New York State (see instructions):

A Employee claimed more than 14 exemption allowances for NYS A

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

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

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

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

Changes effective for 2020

Form IT-2104 has been revised for tax year 2020. The worksheet on page 4 and the charts beginning on page 5, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2020 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If the federal Form W-4 you most recently submitted to your employer was for tax year 2019 or earlier, and you do not file Form IT-2104, your employer may use the same number of allowances you claimed on your federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

For tax years 2020 or later, withholding allowances are no longer reported on federal Form W-4. Therefore, if you submit a federal Form W-4 to your

employer for tax year 2020 or later, and you do not file Form IT-2104, your employer may use zero as your number of allowances. This may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You moved into or out of NYC or Yonkers.
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn \$107,650 or more during the tax year.



Justice Center for the
Protection of People
with Special Needs

Applicant Consent Form for Fingerprinting for Justice Center Criminal Background Check (CBC)

**NYS Justice Center for the
Protection of People with Special
Needs (Justice Center)
Criminal Background Check Unit**

Part 1. Applicant Information (Please Print)

Last Name:	First Name:	MI:
Date of Birth:	Applicant type: Employee _____ Volunteer _____ Family Care ___ Operator _____	
Applicant address, city state:		Social Security Number:
Facility/Provider Name:		

Part 2. Attestation

1. I have been advised that as part of the application process, the facility or provider agency listed above must request a background check with the NYS Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI) and the Justice Center must review and evaluate the results received from DCJS and the FBI. A conviction for certain crimes may affect my suitability for employment in this position.
2. I consent to having my fingerprints taken and submitted to DCJS and the FBI and consent to the Justice Center sharing with the facility or provider agency listed above a summary of the NYS criminal history information, if any, returned by DCJS, as part of its background investigation of my suitability for employment or volunteer service, or for certification as a natural person operator.
3. I have been advised that procedures exist for me to obtain, review and, if necessary, seek correction of my criminal history information pursuant to regulations established by DCJS in 9 NYCRR Part 6050, and the FBI, as applicable.
4. I have been advised that I have the right to withdraw my application for employment or volunteer service, or certification as a natural person operator, without prejudice, any time before employment, volunteer service, or certification as a natural person operator is offered or declined, regardless of whether the authorized person of the facility or provider agency has reviewed the summary of any criminal history information.
5. I have been advised that the results of the criminal background check forwarded to the Justice Center shall be confidential pursuant to the applicable federal and state laws, rules and regulations, and shall only be disclosed to persons authorized by law. Criminal history information will be considered pursuant to Article 23-A of the NYS Correction Law in making hiring determinations.
6. I affirm that the fingerprints submitted will be my own and that the information I have provided is true, complete and accurate.
7. I certify to the best of my knowledge that I: (check as appropriate)
 - (a) _____ have not been convicted of a crime.
 - (b) _____ have been convicted of a crime in NY or other jurisdiction.
 - (c) _____ have pending arrest charges.
 If (b) or (c) is checked, provide details: _____

8. I have been advised that my social security number is being requested so that the Justice Center may check whether I am on the Staff Exclusion List as required by Social Services Law and will be performed prior to the criminal history information check.

You have not been convicted of a crime if:

- a. Your conviction was sealed; dismissed; reversed; resulted in a youthful offender (YO) or juvenile delinquency (JD) adjudication; resulted in a conviction for a non-criminal violation offense; or if you were acquitted;
- b. you received an Adjudgment in Contemplation of Dismissal (ACD) and the adjournment period has elapsed; or
- c. you withdrew your plea after completing a treatment program, and were not convicted of a felony or misdemeanor.

Applicant Signature		Date:
Guardian signature if under 18		Date:
Part 3		
Facility or Provider Agency Authorized Person Information		
Authorized Person Name:	Simi Lev	Title: HR Coordinator
Signature:	<i>Simi Lev</i>	Email: slev@rayim.org



Applicant Info Sheet for Fingerprinting

Last Name: _____

First Name: _____

Maiden Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ - _____ - _____

Date of Birth: ____/____/____

Gender: Female Male

Height: Feet: ____ Inches: ____ Weight: _____

State of Birth: _____

Citizen Country: USA Other: _____

Race: White Black Asian Unknown Prefer not to answer Other _____

Ethnicity: Hispanic Non-Hispanic Unknown Prefer not to answer Other _____

Eye Color: Black Blue Brown Green Hazel

Hair Color: Bald Black Blonde Brown Gray

Please indicate a convenient time to schedule your appointment:

Day: _____ Time: _____:_____



Affordable Care Act (ACA) – Health Insurance Offer Letter

The implementation of the Employer Mandate Provision of the Affordable Care Act was effective January 1, 2015. Compliance with this mandate requires Rayim to offer health insurance benefits to employees who work a minimum of 30 hours per week. ACA requires employers to track the hours worked for each employee and determine health insurance eligibility for active employees.

You may be eligible for health insurance coverage for the current plan year, or as long as you are employed at Rayim. Ongoing eligibility, after this plan year, is not guaranteed and is determined by each measurement period.

Please review the following rate information and return the enclosed form to Human Resources, along with your enrollment documentation.

Health Plan: 2018-2019 Monthly Premiums

Insurance provider	Coverage	Amount	Employee contribution
Empire BCBS	Employee only	\$693.66	9.5%

*Eligibility is reevaluated based on your hire date or every twelve month stability period running September 1, 2018- August 31, 2019 of each year. Qualifying in 2019 does not guarantee you will qualify in future years.



Affordable Care Act (ACA) – Health Insurance Offer Letter

Date _____

I _____ affirm that I have received the ACA notice letter and was informed of my rights to participate in Rayim’s Health Insurance coverage. I understand that the Health Insurance Coverage pertains only to individuals working more than 30 hours weekly.

_____ I would like to participate in Rayim’s insurance.

_____ I decline this offer.

_____ This offer is not applicable for me, since I am working less than 30 hours weekly.

Print Name _____

Employee Signature _____

7. List all employment history serving people with developmental disabilities that occurred beyond 7 years. Write "none" if there is no history. Use an additional sheet if needed.

Full Name of Employer	Location (e.g., city, state)	Start Date	End Date

8. List all volunteer work for the past 7 years and volunteer work serving people with developmental disabilities at any time. Write "none" if there is no history. Use an additional sheet if needed.

Full Name of Agency/Organization	Location (e.g., city, state)	Start Date	End Date

I CERTIFY that the information provided in this form is true and correct to the best of my knowledge and belief, and authorize investigation of all information given.

The provision of false information is grounds for dismissal.

SIGNATURE: _____ DATE: _____

AGENCY CERTIFICATION: I certify that I have reviewed the employment/volunteer history provided by this applicant and that, to the best of my knowledge, the applicant has no employment/volunteer history in the OPWDD system. I also certify that I am an individual designated as an "authorized person" who is authorized to request and receive criminal history information pursuant to exec. L. 845-b.

SIGNATURE: _____ DATE: _____

If the Provider of Services agency has certified the applicant has no employment/volunteer history with OPWDD, the agency may hire the applicant and must retain this form as documentation.



DSP Salary Agreement

This form needs to be **agreed upon, signed and updated** on a new form (with every new hire, new title, and/or new salary rate) by the parties stated below:

- Provider Agency
- Parent/Guardian/Identified Adult
- Direct Support Personnel (DSP)

Please complete the following:

Name of Individual: _____

Individual's legal Guardian:

- Name: _____
- Phone Number: _____
- Address: _____

Name of Hired DSP: _____

DSP's email (if any) and Phone Number: _____

Effective Date of agreement: _____ - _____ (Month-Year)

Title: DSP (Direct Support Personnel) for the following services:

- | | |
|---|--|
| <input type="checkbox"/> Direct provider purchased Community Habilitation | <input type="checkbox"/> Self-hired Community Habilitation |
| <input type="checkbox"/> Direct provider purchased Respite | <input type="checkbox"/> Self-hired Respite |
| <input type="checkbox"/> Direct provider purchased Day Habilitation | |

Hourly Pay Rate: _____ Check off for New hourly pay Rate

Signature/Date of parent/Guardian/Identified adult: _____

Signature/Date of DSP: _____

Signature/Date of Program Director _____

We appreciate your participation to this matter, and look forward to your responses. This form should be returned via mail (2 Van Buren Dr. Suite 101, Monroe, NY 10950), fax (845-782-7800) or email (slev@rayim.org.)

Thank You.

For HR use only

Date received: _____

Date entered into payroll system: _____